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ABSTRACT

This is the third in a series of reports summarizing the investment of the W. K. Kellogg Foundation in community-based health programming. It addresses the health issues confronting young people in U.S. society by profiling eight different community-based approaches to adolescent health. The programs described, all sponsored by the Kellogg Foundation, offer lessons for others designing and implementing adolescent health programs. The following programs are described: (1) TRUST: Teaching Respect, Understanding, Self-Esteem, and Togetherness for the Development of African-American Youth (East Tampa, Florida); (2) Lummi Cedar Project (Belingham, Washington); (3) Adolescent Family Life Program (Sunland Park, New Mexico); (4) Center for Black Women's Wellness (Atlanta, Georgia); (5) The Corner Health Center (Ypsilanti, Michigan); (6) Boys, Girls, Adults, Community Development Center, Inc. (Marvell, Arkansas); (7) Boston Unites To Raise Its Children (Boston, Massachusetts); and (8) New Chance, Manpower Demonstration Research Corporation (Detroit, Michigan; Allentown, Pennsylvania; Lexington, Kentucky). Lessons learned form these programs highlight the need for comprehensive and coordinated services with multiple points of access, including efforts to address employment and economic development issues. A list of 48 resources for further information is included. An executive summary of this report is contained in a separate document that has been included in this same accession. (Contains 86 references.) (SLD)

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ED 434 190

# Safe Passages Through Adolescence

## Communities Protecting the Health and Hopes of Youth

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## Lessons Learned from W.K. Kellogg Foundation Programming

W.K. KELLOGG FOUNDATION

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The W.K. Kellogg Foundation was established in 1930 "to help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations." Its programming activities center around the common visions of a world in which each person has a sense of worth; accepts responsibility for self, family, community, and societal well-being; and has the capacity to be productive, and to help create nurturing families, responsive institutions, and healthy communities.

To achieve the greatest impact, the Foundation targets its grants toward specific focal points or areas. These include: health; food systems and rural development; youth and education, and higher education; and philanthropy and volunteerism. When woven throughout these areas, funding also is provided for leadership; information systems/technology; efforts to capitalize on diversity; and family, neighborhood, and community development programming. Grants are concentrated in the United States, Latin America and the Caribbean, and southern Africa.

# Safe Passages Through Adolescence

## Communities Protecting the Health and Hopes of Youth

Lessons Learned from W.K. Kellogg Foundation Programming

W.K. KELLOGG FOUNDATION

W.K. KELLOGG FOUNDATION

To help people help themselves

April 1998

The W.K. Kellogg Foundation
One Michigan Avenue East
Battle Creek, MI 49017-4058

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# *Foreword*

*Safe Passages Through Adolescence: Communities Protecting the Health and Hopes of Youth* is the third in a series of reports summarizing the W.K. Kellogg Foundation's investment in community-based health programming. *Timely Opportunities* (1995) focused on projects targeting community care of the elderly. *Keeping Tomorrow in Sight* (1996) described models for improving the health and well-being of mothers and their children. Both documents detailed workable approaches to providing comprehensive, holistic, primary care and prevention services within the context of demographic shifts and a changing political climate.

*Safe Passages* addresses the health issues confronting young people in our society—the conditions that shape their prospects and the solutions some communities have found to safeguard their health and hopes. The journey to adulthood is a difficult one under the best of circumstances. For adolescents in vulnerable communities, the transition can be perilous. The models grantees share with us underscore the value of finding approaches that draw on the strengths of people, families, communities, institutions, and diverse cultures. The "safe passages" they suggest may be very different from one another, but the outcome they seek—healthy, hopeful, responsible, productive adults—is common to all.

Since 1930, the Kellogg Foundation has made health programming a priority in hundreds of funding efforts. In recent years, the focus on community-based approaches to improving health has generated lessons useful to decisionmakers in the programming, academic, and public policy arenas. Individual projects may be specific to the culture or circumstances of a particular community. But the broad principles that undergird innovative community-based approaches have much to teach us about investing soundly for the future. The lessons in the pages that follow—lessons about the value of increasing access, creating comprehensive systems of care, forming partnerships, and integrating primary care, prevention, and public health—are a part of this continuum of learning.

We offer *Safe Passages* as a resource for others engaged in the work of improving adolescent health—and a guide for decisionmakers whose labors shape the institutions and policies that define modern life. Through the experience of Kellogg Foundation grantees, we can better recognize the conditions that challenge our young people and identify actions leaders in health care, academe, philanthropy, and public policy can take to support communities protecting the health and hopes of their youth.

*William C. Richardson, PhD*

*President and Chief Executive Officer*

*W.K. Kellogg Foundation*

## *Introduction*

Since the earliest days of civilization, adults have expressed fear that the young people among them will come to no good. Most societies engage in general worrying about young adults. The ancient Greeks blamed the teachings of Socrates for their unruly youth. We credit drugs, guns, rap, and media violence for ours. Adolescents, it seems, are destined to be the repository of our fears about the future. And the youth of our time are no different.

Our young adults have no real voice in social or political processes, but they are our scapegoats all the same. As a group, their impulsive actions baffle or shock us. We know only too well the consequences of experimentation with alcohol, drugs, sex, and gangs. But they seem unwilling or unable to accept our experience. In frustration we label them, reducing their individual needs and circumstances to a series of headlines. In our minds, they become "teen moms" or "generation X"—"young killers" or "gang members." We fear them. We seek to constrain them. And when we cannot, we punish them.

But in this process we seem to forget that the faceless "youth" we label and sometimes fear are the sons and daughters of my brother, your sister, someone's cousin or uncle or niece. Young people in our communities are somebody's children and, as such, unmistakably connected to the fabric of families, neighborhoods, and institutions that link all of us. First and foremost, adolescents are our children—yours and mine.

Few in our nation question what small children need to grow. Defenseless young need safe, warm, protective environments and the care of individuals willing to love, nurture, defend, and teach them. However, we are less clear about how to provide love, direction, stability, and safety to adolescents as they pass from childhood to adulthood.

As every adult survivor of adolescence will admit, the mysteries of this passage are many and the ways to navigate it as unique, perhaps, as the young people who enter it. Teenagers in the midst of this transition are buoyant or despondent, energetic or seemingly misdirected, vulnerable, sullen, sad, needy, or fiercely independent—and often all at once. Do young people need encouragement or tough love? we ask ourselves. Do they need reassurance and assistance or "a swift kick?" Although intellectually we may acknowledge the developmental stresses of the years from ages 11 to 19, we have great difficulty dealing with the behavior that results. And we know of no sure way to make the harrowing journey to adulthood. Adolescents, we sense uneasily, can somehow tell that we do not know.

Yet, for too many of our young people—especially the poor and young people of color—the internal demands of adolescence are magnified by external circumstances beyond their control. These youngsters often come of age in communities where options are limited and the safety and well-being of all residents—children especially—are "at risk." These young people seem to suffer the pains of passage through adolescence in greater measure. Entering the teen years with more precarious health, more limited access to resources, and seemingly less active family support regardless of the causes, these young people face greater peril during the transition. Their ability to move through adolescence and emerge healthy and

hopeful—with the necessary tools and experiences to assume the responsibilities and challenges of adult life—is severely limited.

To some extent, youth in fragile communities fall victim to the actions—and inaction—of our policies and institutions, our practices and traditions. Fragmented health systems, the crumbling infrastructures of urban areas, the limited economic options of isolated or impoverished communities—these are consequences of adult choices, adult decisions, adult perspectives and beliefs on how best to build a safe society.

As a society, we are quick to recognize how young people's actions may harm themselves or others. But we are less willing to examine why they act as they do—less willing, perhaps, because the fault may lie not only with them, but with us, too. The weapons of destruction that threaten so many young people—guns, drugs, decaying schools, and poverty—are not of their creation, but ours.

When young people have no way to express what they experience and no mechanism for changing life as they see it, violent and self-destructive actions convey the depth of their hopelessness. Rather than address the conditions many adolescents face, decisionmakers pursue policies advocating tougher penalties and prison expansions to incarcerate more of our young people. (Some communities even welcome the economic and employment opportunities building new prisons may offer.) But our grantees show us other solutions that can provide a more lasting form of community security. Healthy, productive, responsible adults, they assure us, are the only real safety net for society.

Grantees urge us to develop community networks of services to protect our young people today and ensure our safety—and society's—tomorrow. Accessible, culturally-friendly, primary health care and prevention; enabling services that complement treatment; multiple tiers of connections reaching out to both adolescents and their families—these are common sense approaches to protecting the well-being of young people and safeguarding communities. Commitment to these approaches, grantees say, can turn the perils of youth into the promise of our nation.

In the sections that follow, we describe the challenges young people face and offer a synthesis of grantees' experience. *The Journey to Adulthood* provides background on the health and social conditions that affect adolescents. *No Clear Course* identifies the public policy and health market factors that further shape the health and prospects of young people. In *Promising Paths*, Kellogg Foundation projects are profiled to illustrate the range of approaches to safeguarding the health of adolescents. *Safe and Sound* details the lessons learned from Kellogg Foundation programming related to adolescent health. And *Getting Our Bearings* summarizes both the implications for health care and program development, and the principles that undergird sound private and public policy and practices. This report also includes a *Resources* section containing contact information for related Kellogg Foundation projects and other organizations focused on the health and well-being of young people, as well as a complete listing of *References* for more background on the issues.

*As a society, we are quick to recognize how young people's actions may harm themselves or others. But we are less willing to examine why they act as they do—less willing, perhaps, because the fault may lie not only with them, but with us, too. The weapons of destruction that threaten so many young people—guns, drugs, decaying schools, and poverty—are not of their creation, but ours.*

We want our young people to grow into model citizens. We want them to achieve more than we have, to be more resilient and better than we are. But to do so we must acknowledge and address the factors that threaten their healthy development in the adolescent years. Only by recognizing the forces that shape their todays will we be able to protect all of our tomorrows. Through the eyes of Kellogg Foundation grantees we can see many practical strategies for pooling community resources to protect adolescent health. These approaches—and the determination they are witness to—suggest the safe passages all of us must seek to ensure a promising future.

*Henrie Treadwell, PhD*

*Program Director*
*W.K. Kellogg Foundation*

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# *The Journey to Adulthood:* America's Youth

If every generation bemoans its youth, are the conditions of our young people really so worrisome? Looking only at traditional health indicators, some would argue that U.S. adolescents are in much better health than their counterparts in past generations. Moreover, the times we live in are prosperous according to a great many measures. Since 1970, per capita income has risen, infant mortality has been cut in half, and the proportion of educated adults has risen substantially (Farley, 1997). Are we witnessing actual warning signs or responding to exaggerated claims and the media's tendency to sensationalize bad news?

Certainly, the transition from childhood to adulthood has never been easy for young people or adults. Hormonal changes, cognitive development, and the need to assert independence have always translated into defiant behavior, peer clannishness, and distance from family members in the adult's experience. How, we might ask, are the conditions of adolescents today more dire than those of past generations?

A number of factors support a genuine cause for concern. For one thing, the numbers of young people are growing and, as such, they represent a greater proportion of the population. The teenage population is expected to rise by as much as 20 percent in the next 10 years and the percentage of poor, minority teens to increase even more. In 1992, 34 million young people (ages 10-19) comprised 14 percent of the population. By 2020, it is estimated that number will have grown to 43 million. (U.S. Bureau of the Census P25-1111, 1994; U.S. Bureau of the Census PPL-8, 1993)

The number of young people of color grew by almost 28 percent between 1980 and 1991 (U.S. Bureau of the Census PPL-8, 1993). The one-third these young people represent today is expected to balloon into almost half the adolescent population by 2050 (Carnegie Council on Adolescent Development, 1996).

Percentages of Young People of Color in the U.S.*

*youth ages 10-19 in 1992
Source: U.S. Bureau of the Census PPL-8, 1993



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As the number of young people increases, the proportion of our youth living in poverty swells as well. The children of families of color are far more likely to live in poverty than other children in the United States. One of every three Hispanic children lives in poverty. Among African-Americans, that number increases to one of every two. And an estimated nine of ten Native American children live in impoverished households. (Elders, 1994)

For young families of color, the prospects are even more alarming. In 1991, 31 percent of young white families lived in poverty, compared with 67 percent of young African-American families, and 46 percent of young Hispanic families (U.S. Bureau of the Census P60-185, 1993).

With poverty comes a familiar array of health and societal challenges. Poverty is correlated with an individual's access to health care, education, employment, housing, exposure to violence, and a great many other determinants of health. Again and again as a society we come face to face with evidence of the difficulty of extending opportunities to all. The poor, minorities, and those isolated by social or geographic barriers suffer the shortfalls of our society disproportionately across every measurable variable.

- *Low-income children in the United States are far more disadvantaged than their peers in all but two of 18 other Western industrialized nations. Even with the value of U.S. social welfare programs (food stamps, earned income credits) added to family income, children at the bottom end of the income distribution scale have far lower incomes if they live in the United States than if they live in other industrialized nations—except for Ireland and Israel. (Rainwater and Smeeding, 1995)*
- *A male high school graduate's mean monthly income is likely to be twice as much as that of a female high school graduate. Yet an increasing number of U.S. households are headed by single women. Despite significant gains by women in workforce participation rates and increasing responsibility for family income, the majority of women are still employed in technical, sales, and clerical occupations. (U.S. Bureau of Labor Statistics, 1996)*
- *Women are the fastest growing population in U.S. jails and prisons. The number of incarcerated women increased three-fold between 1980 and 1990. Two-thirds of women in state prisons had at least one child. As a group, they were mothers to more than 56,000 children. More than half of women in prison never see their children during incarceration. And 40 percent of women prisoners report physical or sexual abuse prior to incarceration. (U.S. Bureau of Labor Statistics, 1994)*
- *Children comprise 34.6 percent of the nine million rural poor. Of these, only 17.6 percent live in families with both a mother and father present. (Sommers, 1997)*

*"The main determinant of children's health is the physical and social environment in which they grow."*

*— L.V. Klerman*
*Department of Maternal and Child Health, University of Alabama at Birmingham*

*"There will be trouble ahead, and the problem is, we are not planning for it...or to avoid it."*

*— J.A. Fox*
*Dean of Criminal Justice, Northeastern University, Boston*

- *The overwhelming majority of rural poor are white, but black rural poverty is concentrated in the south. Of the 6.6 million whites who live in rural areas in poverty, only 2.9 percent live in southern states. At the same time, 96.8 percent of the 2.1 million African-Americans living in rural poverty live in the south. (Sommers, 1997)*
- *At least 69 percent of all residents of inner cities were poor in 1990. Poor people of color tend to live in concentrated communities while poor whites are more spatially dispersed. (Fossett and Perloff, 1995)*
- *In the period from 1991-94, the shift toward segregated education for blacks was the greatest since the Brown v. Board of Education decision in 1954. According to the Harvard Project on School Desegregation, Latinos are even more likely than African-Americans to be isolated educationally. Says study coauthor Gary Orfield, "They're being locked into inferior, impoverished schools, and that means their future is threatened." (Adams, 1997)*
- *Children of minority groups are at a higher risk for specific acute and chronic health problems, such as asthma and AIDS (Klerman and Perloff, 1997).*

The greater a family's limitations—in opportunity, education, and health—the more significant the impact on young people. Employment status of the parent is considered by many to be the most significant indicator of a youngster's well-being. Just as parents with adequate income can care for their children and plan for the future, communities with low unemployment are more stable, too. In these communities, schools and other pivotal institutions are more likely to function well. (Tollett, 1993)

The persistent and widening gaps between low-income and other children can be related in part to educational achievement. School failure—a low grade point average or being "held back" a year in school—is linked to a variety of high-risk behaviors in adolescents regardless of family economic circumstances (Resnick and others, 1997). Certainly, the U.S. high school dropout rate is costly in terms of lost earnings and uncollected taxes. But this effect pales if measured against the loss of human potential. By pushing too many to the margins of society, human spirit is diminished. The short-term result is a great many hopeless young people. But the long-term consequences are more sobering. Ultimately, many experts believe, the burdens of low expectations and educational attainment of our young will rest on all of us, not just upon the shoulders of the poor.

### Adolescent Health Risk Behaviors

Tobacco use

Alcohol, marijuana, and other drug use

Suicidal thoughts and behaviors

Early sexual activity

Violence

### Factors That Can Be Related To Adolescent Health Risk Behaviors

Ease of access to guns at home (suicidal thoughts and behaviors, violence)

Access to cigarettes, alcohol, and other substances at home (cigarette and substance use)

Working 20 or more hours per week (emotional distress, cigarette and substance use)

Appearing older than most peers (emotional distress, suicidal thoughts and behaviors)

Repeating a grade in school (emotional distress and tobacco use)

Source: Resnick and others, 1997

*"The negative impacts of poverty, racism, and environmental degradation—inextricably tied to the structure of our economy—cannot be denied and must be addressed."*

*(Stein and Tassi, 1997)*

## *Adolescent Health Status: The Consequences of Poverty and Social Isolation*

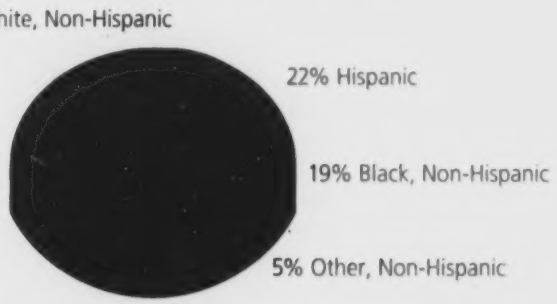
Adolescence is a time of burgeoning independence and preparation for adulthood. But even as young people are striving to loosen family ties, their prospects remain closely bound to the economic status of their relations.

Children living in poverty are often in poor health compared with children from more affluent families. Good health depends upon preventive services and access to primary health care. But prevention and access to services are difficult without adequate resources. The more financial resources a family has, the more likely the children will be healthy (Coiros, Zill, and Bloom, 1994).

Yet since 1989, the number of children without health insurance coverage has grown by an average of 1.2 million a year, or nearly 3,300 a day. At this rate, an estimated 13 million children would be uninsured in the year 2000. (Women's Network for Change, 1997)

Approximately 16 percent of youth ages 13-17 have no health insurance. As with other uninsured children, a disproportionate share of uninsured adolescents are poor, members of a minority group, or both. Twenty-two percent of uninsured children are Hispanic. African-Americans make up 19 percent, and other minorities 5 percent. (Families USA Foundation, 1997)

## Racial Makeup of Uninsured U.S. Children*




*youth ages 13-17
Source: Families USA Foundation, 1997

## *A Comprehensive Model for Adolescent Health Care*

The current illness-focused system has few access points for young people. A comprehensive model for adolescent health care must include services to address physical and mental well-being, and mechanisms for referral and follow-up. Highly integrated collaboration among schools, health and human service providers, community development agencies, neighborhood organizations, and other local resources ensures that access to care is not hindered by cost, hours of operation, distance, transportation, or other factors. And connecting with the root causes of adolescent ill health will make it possible to move beyond treating symptoms to address community health issues.

Even with health insurance, real access to services is limited for many families. The need to take unpaid time off from work to seek health services is a barrier to access for many working families. And in many regions, a family's ability to reach providers may be constrained by great distances or lack of transportation. For others, the lack of health providers to serve a particular area may be the greatest barrier to access. (Ornstein, 1997)

In addition to a lack of health insurance coverage, young people must negotiate for services in a health system that lacks a primary care infrastructure. Health systems with a strong primary care infrastructure in other industrialized countries tend to distribute services more equitably across their populations—and reduce barriers to care that especially impede access by the socially disadvantaged (Starfield, 1992). Adolescents in general are reticent to seek medical care except in an emergency. Those who do come into contact with our fragmented delivery systems may face as many barriers within "the system" as outside of it.

The disparity in health status between low-income and other children widens when morbidity and mortality are measured. Poor health is correlated with lower income, less education, racial or ethnic minority status, and other social variables (Montgomery, Kiely, and Pappas, 1996). Children of low-income families die at greater rates than more affluent children, and they have greater disability than high-income children, even with the same diseases (Starfield, 1997).

### Symptoms of Adolescent Ill Health

25% of young people are victims of assault

12.5% suffer injuries related to being victimized

10.5% are sexually assaulted or abused

Marijuana use has doubled among eighth graders since 1991

Source: a national survey of adolescents age 10 to 16 (Joffe and Wilson, 1995)

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*Among the social trends that comprise the adolescent health landscape, changes in the family structure, the prevalence of teen pregnancy, the effects of violence, and the consequences of risky behavior—substance abuse, smoking and other tobacco use, and early sexual activity—are of particular concern.*

## *Family Structure*

More than 19 million children in America grow up in a household without a father. One-quarter of these children—in every state but Utah and Wyoming—live in neighborhoods where more than half of all families have no father in the home. Children who grow up without fathers are five times more likely to be poor, and almost 10 times more likely to be extremely poor. They also drop out of school at twice the rate of other young people and are significantly more likely to find themselves in foster care or juvenile justice facilities. (Annie E. Casey Foundation, 1995)

The number of children living with single mothers increased from 6 percent in 1950 to 24 percent in 1994. This trend has been matched by an even more rapid rise in the percentage of young men with earnings below the poverty level. Many suggest a correlation between the decline in earnings of poorly educated, less-skilled young men and the increases in unwed mothers and single-parent families.

### Risk Factors for America's Youth

Living in poverty

Welfare dependence in the family

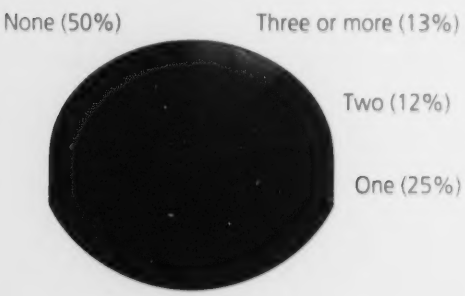
Both parents absent

Single-parent families

Unwed mothers

Parent who has not graduated from high school

### Percent of Risk Factors Among 16- and 17-Year-Olds




*Source: U.S. Bureau of the Census, 1997*

Since 1972, the percentage of men (ages 25-34) with earnings below the poverty level increased from 14 to 32 percent. Low earnings for men are correlated with reduced marriage rates. Among men in their 30s, those earning $50,000 a year are nearly twice as likely to be married as those earning less than $10,000 a year. (Annie E. Casey Foundation, 1995)

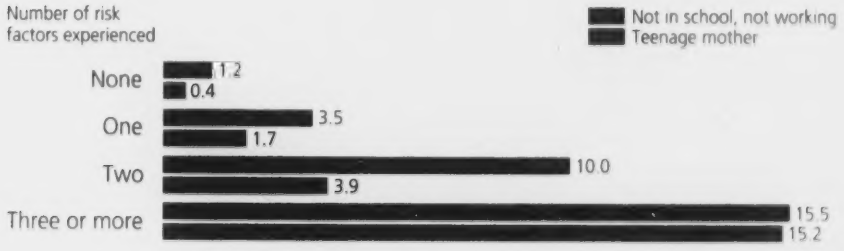
Although the children of single mothers living below 150 percent of the poverty level are more likely to be in poor health than the children of two-parent families, poverty appears to be the strongest determinant of poor health (Montgomery, Kiely, and Pappas, 1996). Despite these facts and growing evidence of the likelihood of poverty, the rate of teen parenting continues to remain high.

## *Violence*

In 1994, 8,116 young people ages 15 to 24 were homicide victims—an average of 22 youth homicides each day. The homicide rate for young men increased from 22 to 37 per 100,000 in the period from 1987 to 1991. Researchers note that the adolescent suicide rate has increased by 75 percent in the last ten years. And the results of one study indicate that urban youngsters frequently witness violence—ranging from physical assault to sexual assault and shootings. Given that homicide, suicide, and unintentional injuries account for three of four deaths to young people today, violence represents as great a threat to children's health as any disease. But we have yet to respond with the intensity required to address violence as a public health menace. (U.S. Centers for Disease Control and Prevention, 1996; U.S. National Institute of Justice, 1996; Prothrow-Stith, 1996; Snyder, Sickmund, and Poe-Yamagata, 1996; Resnick and others, 1997; Walker, Goodwin, and Warren, 1992)

Young people, especially those who perceive themselves as excluded from mainstream opportunities, are at great risk for becoming the victims of violence (Novello, 1991). The correlation between violence and poverty is a strong one—stronger, in fact, than the correlation between violence and race or ethnicity (Elders, 1994). And an adolescent who was abused or neglected as a child has a far greater likelihood of being arrested as a juvenile (Barrett, 1993).

Risk Factors Related to Adverse Outcomes Among 16- and 17-Year-Olds




*Source: U.S. Bureau of the Census, 1997*



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Homicides are a leading cause of death among young people, and youth are increasingly victims of crime. From 1973 to 1990, crime rates for youth increased 36 percent for young people ages 12 to 15, and 27 percent for those ages 16 to 19. (U.S. Bureau of Justice Statistics, 1992)

The price tag for the care of young firearms victims alone is staggering. In 1993, the cost of providing emergency transportation, medical care, rehabilitation, and related treatments to victims ages 10 to 19 was $407 million (Miller, 1995).

At the same time, some estimates suggest more than half of serious crimes (assault, robbery, burglary, motor vehicle theft, larceny, rape, murder) are committed by young people. From 1988 to 1992, arrests of young people for violent crime rose 47 percent. In roughly the same time period, the percentage of incarcerated juveniles from minority groups rose from 53 to 63 percent. This included an increase from 37 to 44 percent for African-Americans, and 13 to 17 percent for Hispanics—at an annual cost of around $33,000 per prisoner. (*The Washington Post*, 1994; Winbush, 1988; Barrett, 1993; HandsNet Forum, 1994)

The cost of maintaining our prison system is approaching $40 billion a year (Davidson, 1997). In some states, prison system costs exceed the cost of supporting the state's higher education system. The message is clear: It is less costly to educate than to incarcerate. (Barrett, 1993)

## *Teen Pregnancy*

Experimentation with sexual activity is common among adolescents across cultures. But in the United States, the teen birth rate is still higher than it was 20 years ago and the overall rate remains the highest in the developed world. Each year about one million adolescents become pregnant, most of whom are unmarried teens.

The health issues that face childbearing adolescents are well documented. The medical needs of childbearing teens have received a great deal of concentrated health and human services attention in recent decades. The equally serious social consequences—in terms of single-parent households, dependence on public assistance, and the likelihood of lifelong poverty—are also well documented, but less easily addressed.

Although young men and women are generally assigned equal blame for teenage pregnancy, only 26 percent of the young men involved in teen pregnancies were under the age of 18 (Allen Guttmacher Institute, 1994). And while the birth rates are much higher for African-American teens than for white teens, the percentage of increase between 1985 and 1991 was greatest for white teens and for teens under age 15. The birth rate for white adolescents increased by 33 percent in that period compared with 4 percent for African-American teenagers.

*"As adults in a community, we will give the children around us our time, our attention, our money, and our resources—one way or the other. It is through public policy that we decide whether it's going to be early on, in a loving and preventive way, or whether it's going to be at 4 o'clock in the morning when they are throwing bottles at cars to hear the alarms go off."*

*—D. Prothrow-Stith*
*Assistant Dean, Office of Government & Community Programs, Harvard School of Public Health, Cambridge, Massachusetts*

Among young people ages 15 to 19, the birth rates for whites increased by 27 percent compared with 15 percent for African-Americans (U.S. Centers for Disease Control and Prevention, 1993). However, researchers note that white women were more likely to terminate unintended pregnancies than either African-American or Hispanic women. Socioeconomic status, level of parental education, and plans for the future are other variables that distinguish young women who terminate pregnancies from their childbearing peers (Cooksey, 1990).

The forces that place a young girl at serious risk of teen pregnancy and long-term welfare dependence begin early. Girls who grow up in abusive families or impoverished neighborhoods are at greatest risk. Two-thirds of a sample of young women from the state of Washington who became pregnant as teens had been sexually abused (Boyer and Fine, 1992). All too often, services for girls 10 to 15 years old who live in risky situations are limited. But when a crisis occurs—usually pregnancy—services seem to be available in abundance. However, many experts question whether the medical and human services offered at such a time are the most appropriate remedies for the social antecedents that produce teen pregnancy and other adolescent health crises.

Most adolescent parents are living in poverty when their children are born. Many are poor before they become pregnant. But even for those who come from more secure families, the economic and educational limitations of early childbearing are daunting. Fifty percent of young women who become pregnant as teens never receive a high school diploma. And a majority of teen fathers do not receive a high school diploma by age 20. (Montana Kid's Count, 1996)

Teenage pregnancy is a public health issue requiring interventions that address underlying issues—poverty, unemployment, abuse and neglect, and school success.

## Children Born to Teen Mothers are More Likely to:

Be low birth weight (less than 5.5 pounds at birth)

Live in poverty

Experience child abuse and neglect

Experience failure in school

Source: Annie E. Casey Foundation, 1995

## *Substance Abuse, Smoking, and HIV/AIDS*

Adolescence is characterized by experimentation and impulsive behavior. But the health consequences of trying tobacco products, alcohol, and illegal drugs combined with the hazards of unprotected sexual contact are taking their toll on young Americans.

Drug use is on the rise with increasing numbers of younger adolescents trying marijuana and other illegal drugs (Joffe and Wilson, 1995). Drinking among young drivers and binge drinking on college campuses are raising flags in communities across the country. And three decades of data about the dangers of smoking and tobacco use have not blunted young people's attraction to cigarettes. Teenagers, young women especially, are lighting up in record numbers. Warnings about the negative health consequences of chewing tobacco seem to have fallen on deaf ears as well. (Resnick and others, 1997)

Marketers of legal and illegal substances alike target young people—especially youth in fragile communities. The placement of billboards and the images and messages selected to hawk cigarettes and beer clearly illustrate the intention of corporate decisionmakers. The strategic locations of drug dealers—near schools and places where young people congregate—highlight the same thinking. On both sides of the law, adult vendors use loss-lead items and giveaways to draw young people into trying their wares.

Unfortunately, a few years of risky experimentation can predispose a young person to lifelong health problems. Substance abuse and smoking are both physical and social addictions. Habits acquired in the formative years are among the most difficult to break, in part because they are often linked to a young person's developing identity and relations with peers.

Early sexual relations expose youth—in particular, young people of color, the data suggest—to other life-threatening health hazards. African-American and Hispanic youth are disproportionately represented in the number of AIDS cases among young people ages 13 to 24. African-Americans accounted for one-third of the cases reported among males, and 55 percent of all cases among females. Similarly, Hispanic males represented 20 percent and Hispanic females 21 percent, with a large proportion of the cases found among Puerto Rican children. (U.S. Centers for Disease Control and Prevention, 1994; Mendoza, 1994)

## *Family and School Connections Appear to Protect Adolescents*

In September 1997, articles in the *Journal of the American Medical Association* described the Phase 1 results of the National Longitudinal Study on Adolescent Health. The data include survey results of a representative sample of more than 90,000 U.S. 7th- through 12th-graders and interviews with more than 12,000 of the young people surveyed. Acknowledging that adolescent morbidity and mortality are often consequences of risky behaviors, the study seeks to identify risk and protective factors as they relate to adolescent health, violence, substance use, and sexuality.

Although the data continue to document the prevalence of risky behaviors among adolescents, findings suggest that family expectations, the presence of caring parents, and connections to school reduce the likelihood of harmful choices. In an editorial highlighting study results, Jonathan D. Klein, MD, MPH, notes that "the findings provide solid evidence for ways that families and schools can be protective in the lives of teenagers." (Vol. 278, No. 10, p. 864)

The researchers who analyzed the findings relate the results not only to individual and family choices, but also to social and economic policies. For instance, Michael Resnick and his colleagues note that access to firearms, alcohol, tobacco, and other substances in the home put young people at an increased risk of suicide, violence, and substance abuse. But they also suggest that the framework of family

support is another dimension of adolescent health. "As economic and social policies press both parents into the workforce, consideration should be given to the sequelae for children when flexible time options are not made available," they conclude.

The benefit of a substantial body of data to draw from is that it will provide information about adolescent health across gender, ethnicity, and social class variables. But researchers and practitioners are realistic about the potential of information alone. In Dr. Klein's summary he cautions: "Understanding the reasons for adolescents' risky behaviors cannot be expected to improve the health status of adolescents. It is now time to focus resources toward ensuring that effective preventive interventions are available, are delivered, and are used for all adolescents."

*Where poor adolescents and young people of color are equally prey to many health conditions, individual groups experience distinct challenges to securing optimal health and well-being.*

## *African-American Youth*

For many impoverished African-American adolescents, institutionalized racism, personal life experiences, and isolated socioeconomic conditions make the transition to healthy adulthood a riskier process than for their peers in other groups. Forty years ago, E. Franklin Frazier wrote: "The poor health of black Americans was associated with poverty, including poor housing and nutrition." (Frazier, 1957) The causes of poor health among low-income African-American youth are very much the same today.

African-Americans are at risk of health problems with social and behavioral origins (Christmas, 1996). African-American children ages 15 to 17 have a higher percentage of disability than do their white counterparts in the same age group (Klerman and Perloff,1997). And as a society, we are just beginning to realize that many youngsters suffer from a form of traumatic stress syndrome that ultimately manifests in morbidity and mortality data (Bell, 1997).

Today, disparities in both health and economic status continue to exist between African-Americans and whites. In one study, parents said that 41 percent of black children are in excellent health compared to 53.9 percent of white children. African-American children are 16 percent of the U.S. population under 18, yet they comprise 43.8 percent of the children who live in poverty. (Coiros, Zill, and Bloom, 1994; Brown and Pollitt, 1996)

Evidence of stark differences between the prospects of young African-Americans and other groups also abounds. The rate of unemployment for African-Americans is in the double-digits while the overall rate among the general population remains low. Close to one-half of African-American males

between the ages of 18 and 35 are incarcerated. In 1994, nearly one-in-three black men in their twenties was in prison, on parole, or otherwise under the supervision of the criminal justice system—an increase of 30 percent since 1989. (*The Washington Post*, 1995)

Too little reality-based job training, poor education, limited economic development, and discriminatory hiring practices have mitigated or contributed to the continuing erosion of African-American families with the most devastating impact falling on youth. Children and young people are victims of factors outside of their control or the control of their parents. A common theme among providers who treat African-Americans is that racism and racial identity are both the cause and the solution to problems. (Koss-Chioino and Vargas, 1992)

## *Hispanic Youth*

Thirty-one percent of the children of Hispanic working adults are uninsured, compared with only 12 percent of white children. As children, Hispanics are least likely of any group to see a physician. In one study, only 68 percent of Hispanic children with pneumonia saw a physician. Hispanic teenagers are less likely than peers in other groups to seek or use family planning services. And Hispanic youth are more likely than teens in other groups to have considered or attempted suicide. (National Coalition of Hispanic Health and Human Services Organizations, 1996)

As stated earlier, poverty and social isolation are some of the barriers Hispanic youth face. But cultural and language barriers may limit broader understanding of other community health issues. One study indicated Hispanic children are more likely to report fear of attack traveling to and from school. But the fact that 64 percent of Hispanic children live with both parents suggests that factors other than family structure are at the root of social instability. (National Coalition of Hispanic Health and Human Services Organizations, 1996)

Experts say that early access to prevention services is one element to improving Hispanic adolescent health and well-being. Addressing environmental health issues may be another. By one estimate, Hispanic young people are three times as likely as non-Hispanic whites to live with exposure to agricultural pesticides or in areas where other environmental health hazards are present (National Coalition of Hispanic Health and Human Services Organizations, 1996).

Increasingly, the diversity among Hispanic Americans is being recognized as another pivotal factor in crafting approaches to improving health. Mexican immigrants, although still the largest U.S. Hispanic group, have been joined in greater numbers by Cubans, Puerto Ricans, and others from the Caribbean, Central America, and South America. Seeking culturally-appropriate care strategies amid such varied cultures is a growing challenge. Among providers who treat Hispanic Americans, a related common thread is the need to emphasize the diverse psychohistorical experiences of Hispanic peoples as a vehicle for culturally-responsive interventions (Koss-Chioino and Vargas, 1992).

*"Children who live in inner cities and on reservations are more likely to be subjected to chronic social stressors than are their counterparts in other communities."*

*(Canino and Spurlock, 1994)*

## *Native American Youth*

Native American youth have a high incidence of emotional disorders, mental illness, and alcohol and substance abuse compared with other groups (Inouye, 1993; Grossman, Krieger, Sugarman, and Forquera, 1994). Inadequate family income, physical and social isolation, and poor access to health services further hamper the health of Native American young people.

Culturally, Native Americans value community and kinship (Koss-Chioino and Vargas, 1992). But Native American communities face the challenge of their young people rejecting tribal ways even as tribal culture is reemerging as a potent force. Traditional values and rites must compete with the lure of popular culture and the larger society. At the same time that tribal programs are moving to a focus on youth development, youth are becoming more involved in risky behaviors. (National Indian Justice Center, 1995)

Access to health care services remains a challenge for Native Americans whether they live in urban areas or on the reservation. Urban programs for Native Americans received only a small fraction of the Indian Health Service budget in 1996. And self-determination is forcing Native Americans into seeking coverage and health services in the more costly private market (Kunitz,1996). On the other hand, few would argue that services on the reservation are either adequate or easily accessible. Employment opportunity is equally inadequate. Whether Native Americans stay on the reservation or seek opportunities elsewhere, the difficulties of making a living wage and gaining access to needed health services remain significant.

## *Asian American Youth*

A growing number of Asian Americans—many of them recent immigrants—are wrestling with the difficulties of acculturation into a society with a radically different world view (Koss-Chioino and Vargas, 1992). Few data exist to provide a picture of the challenges young Asian Americans face as they move through adolescence. Health professionals working with Asian families report that the number of different types of Asian peoples even among the three general classifications—Pacific Islanders, Southeast Asians (including Filipinos), and east Asians (people of Japanese, Chinese, and Korean origins)—make broad statements about health factors difficult.

But most acknowledge that the expectations of adolescents in Asian American families appear to be high. For recent immigrants, young people become translators of both language and culture for their elders. They also are often expected to succeed in school, care for aging relatives and/or younger siblings, and work in family businesses. At the same time, advocates point out that the misleading identification of Asians as the "model minority" cloud very real health issues for young people and their families—including poverty, involvement in gangs, mental health issues, and reproductive health needs. (Chung, 1997)

One study by the National Research Center on Asian American Mental Health found that Asians are less likely to seek mental health services, but more likely than other ethnic groups to have psychotic disorders. Many Asian cultures also place very different values on young people based on gender. Yet among young women ages 15 to 24, Asian Americans have the highest suicide morbidity rate. (Meadows, 1997; Chung, 1997).

## *The Power and Potential of Commercial Messages*

***If you let me play***
***I will like myself more***

***I will have more***
***self-confidence***

***I will suffer less depression***

***I will be 60% less likely to get***
***breast cancer***

***I will be more likely to leave a***
***man who beats me***

***I will be less likely to get***
***pregnant before I want to***

***I will learn what it means***
***to be strong***

***If you let me play sports***

—Nike advertisement

As you turn the page, a young girl's steady gaze arrests you. You read the powerful words and recognize the familiar Nike emblem. Not just another ad, her image presents a striking contrast to the late Joe Camel—a welcome relief from the beer and cigarette pitches all too familiar from neighborhood billboards and the glossy pages of magazines.

Dr. Ilona Kickbusch says this ad—one she saw in a magazine her son reads—is a potent example of the private sector's capacity to positively impact health. As Director of the World Health Organization's Division of Health Promotion, Education and Communication, Dr. Kickbusch appreciates such examples—and wishes there were more. "I refer to this as a positive illustration of how the private sector can draw attention to women's health issues of a broader nature

without focusing on specific diseases or treatments," she explains.

Dr. Kickbusch and others agree that corporate marketing decisions have bearing on the health and well-being of people—especially young people. The messages teenagers see in the larger environment can either reinforce or contradict what they are hearing at home, church, or school. Youth who grow up without strong voices in any or all of these sectors are especially vulnerable to negative marketing appeals. Commercial messages that target adolescents and encourage risky behaviors contribute to the grave conditions that threaten the health of young people.

*"Young girls play a crucial role in the Asian American family, often given important, mature tasks such as caring for the elderly and acting as translators for their parents' health care visits. However, girls are still tremendously devalued in the Asian family in relation to boys. Asian girls are struck paradoxically by expectations for high achievement and assumptions that they should desire less because they are female."*

—*M. Chung*
*President, National Asian Women's Health Organization, San Francisco, California*

# *No Clear Course:*
## Public Policy, Health Care, and Adolescent Well-Being

Social forces focused on fostering the development of healthy, productive young adults appear to be diminishing, along with resources and the active and vocal commitment of adult citizens to support the development of the next generation. As a result, poor children of all ages, but adolescents in particular, are finding too few public policy or institutional advocates offering options for healthy physical and emotional development, long-term economic stability for families, or realistic educational and employment opportunities.

In 1995, the federal government spent a total of $167.2 billion on corporate business "welfare," or $1,388 per individual taxpayer. By contrast, the government spent a fraction of that figure—$50 billion—on Aid to Families with Dependent Children (AFDC), food stamps, and other forms of social welfare programs, or $415 per individual taxpayer (Pianin, 1995). Even the poor have a share in paying for the maintenance of a healthy economy. Yet their return on the "investment" is often disappointing.

*"The problem with the use of the term 'cost-effective' is that the definition is too narrow. Policymakers do not typically understand cost-effectiveness in terms of what is needed to improve the health of adolescents."*

— *A. English*
*Program Director, Adolescent Health Care Project, National Center for Youth Law, Chapel Hill, North Carolina*

### *Medicaid*

Enrolling all eligible children into Medicaid has remained an elusive problem. In 1994, almost 2.7 million low-income children who had no health insurance were eligible for Medicaid, but not enrolled (Summer, Parrott, and Mann, 1997). Prior to enactment of the State Children's Health Insurance Program in 1997, few states had acted upon the Medicaid option of providing coverage for qualified young people up to age 19. And only a few states modified allowable insurance packages to require preventive care coverage for adolescents or maternity coverage for nonspouse dependents. (Klein, Slap, Elster, and Cohn, 1993)

Medicaid managed care is the accepted cost-containment mechanism nationwide. But the risk aversion that has characterized most managed care organizations raises the question of what its long-term impact on health will be. In general, Medicaid managed care systems are not seen as likely to provide the range of enabling and other services vulnerable families often need.

### *School-Based Health Services*

School-based health services are declining at a time when they may be most needed (Ornstein, 1997). Compared with past generations, few of the nation's young people receive services from a school nurse or clinic. But access issues and time constraints suggest that working through schools may be the best way to reach underserved groups (Coulam and others, 1996).

Data indicate poor youth are only half as likely as young people from more affluent families to identify a source of health care (Klein and others, 1993). Presumption of Medicaid eligibility and active enrollment could be a way of expanding adolescent access to services and funding for facilities. One survey showed that although 35 percent of the primarily low-income students who were using school-based health services had Medicaid coverage, less than 1 percent of the school-based center funding came from Medicaid revenues (McKinney and Peak, 1994).

The challenge for school-based health centers is to become part of the evolving managed care system and enhance access while producing outcomes that control cost (Hacker, 1997). Still, school-based centers may remain the best option for adolescents who live in rural areas where distance to facilities is great and few services of any kind are available, or in the inner city where similar difficulties are encountered with transportation and poor access to quality care.

With new welfare reform policies in place, parents working at low-wage jobs may not have the latitude of taking their children to health care appointments. But parents need assistance to continue to nurture their children's health. In this instance, parental involvement in the design of school-based services may make it possible for a broad array of access and health issues to be addressed.

School-based centers are also well-positioned to implement plans of care that take into account environmental issues that contribute to poor health. A systematic process for giving local people, especially parents, a voice in the development of school-based facilities can expand the reach and scope of school clinics and services. For adolescents who remain in school, school-based health programs have great potential to reach and serve adolescents in a way that is meaningful to them and their families.

## *Managed Care and Market Forces*

Managed care may be able to manage costs in the short-term. And for some groups of children, managed care may improve access over fee-for-service systems—and the improved access may translate into improved health for some. But for vulnerable groups of children and young people—minority children, the poor, and rural underserved—it is less clear whether improvements in access will lead to improved health outcomes.

Sick children, especially those with chronic illnesses or special needs, may be especially vulnerable to adverse health outcomes under managed care. Unless quality of care and an expanded concept of what constitutes primary health care become the norm for service design and delivery, health gains may be limited and health losses significant (Ware and others, 1996). At this writing, states must obtain a federal waiver to enroll children eligible for Supplemental Security Income (SSI), those receiving Title IV-E foster care or adoption assistance, or children in foster care or other placement settings in managed care programs (Child Welfare League of America, 1997). But analysts suggest that public health agencies and providers must evaluate and track the effects of managed care on children and young people with chronic conditions or special needs to ensure their additional care needs are addressed within these systems (Perrin and others, 1997).

*"School-based health centers are now challenged by this changing and complicated health care environment. Although they are less threatened as a unique health care model, they are now fighting for financial survival amid a rising tide of managed care."*

— *K. Hacker*
*President, National Assembly on School-Based Care*

*"Having health insurance doesn't mean kids will have health care—especially preventive care, like vaccinations and well-child checkups that can stave off serious illness down the road. . . . When my kids were younger, every regular checkup meant nearly a full day's commitment at the pediatrician's office for me, my wife or both. It was a pain, but as professionals we could manage the time off. In a house with a single mother working in a fast-food restaurant or cleaning hotel rooms, taking a child for a checkup may mean taking a day off work, losing pay or risking unemployment."*

— *N. Orstein*
*American Enterprise Institute*
*(USA Today, 1997)*

Economic forces are currently driving health care systems and the services they provide. Market share, capitation, and provider concerns are all at the forefront of many health system decisions. Some traditional safety net providers—community health centers, public hospitals, and academic health centers—are losing their Medicaid population to other private plans. As their paying clients dwindle, some face an environment fraught with financial peril as they look for ways to afford the uncompensated care they have historically provided. The free care they have always provided to the poor and their children may be at risk in this shifting scenario.

No one will argue that change was necessary to control rapidly escalating health care costs. But we live in a country with no consensus about what should comprise effective health service delivery. Nor have current plans addressed local economic, cultural, and social factors that perpetuate poverty and attendant high levels of morbidity and mortality among the poor and people of color as they fail to seek care on a timely basis or use appropriate settings when they do.

While health care costs rose only 6.4 percent in 1994—the lowest rate of increase in 30 years—no data are available to suggest that vulnerable populations are faring any better under the new systems. Recent analysis suggests that even case management, when limited to the provision of medical services and health counseling, has no marked impact on populations that experience persistent levels of poverty (Schulman, Sheriff, and Momany, 1997).

Typical managed care operations are not integrated beyond the confines of traditional medicine. They do not seek to provide comprehensive, holistic services to children and their families. Nor do providers or managed care agencies seem able or willing to collaborate more broadly across health, social services, and community development disciplines.

The ultimate impact is that people continue to suffer while agencies tally the "body count" in terms of unemployment, homelessness for children and their families, school dropout rates, or low achievement. All of these and more are related, but providers seem wary of sharing resources and resistant to social and systems change strategies. In the long run, health care reform measures that ignore nonfinancial barriers to care—barriers related to age, sex, race, ethnicity, and isolation—may not be effective in ensuring that children and young people receive needed care (Shenkman and others, 1996).

## *Welfare Reform: The Personal Responsibility and Work Opportunity Act*

Welfare reform measures to reduce the number of out-of-wedlock births by denying cash benefits to unwed mothers sidestep a number of crucial issues. Focusing on increasing educational and occupational opportunities for both women and men might well provide a more solid framework for policy approaches. Under the current structure, welfare recipients may respond to what they perceive as a policy-driven incentive to change residence and family structure frequently (National Science and Technology Council, 1997). Such residential mobility may quash any envisioned financial benefit to public agencies. It also may place additional burdens on children and young people who will suffer most from frequent changes of residence and schools.

The number of children who are poor and extremely poor may increase due to welfare reform legislation. The Personal Responsibility and Work Opportunity Act of 1996 terminates income support for many and significantly curtails income support for families now receiving cash assistance, including families with children with disabilities. Given the strong relationship between income and child health, as well as the legislation's health care restrictions, the Act presents a serious threat to the health and well-being of children (Rosenbaum and Darnell, 1996).

Reducing income support for low-income families may increase homelessness and the number of families living in inadequate and unsafe housing, as well as worsen the nutritional status and overall health and development among children and young people (Geltman, Meyers, Greenberg, and Zuckerman, 1996).

## *The State Children's Health Insurance Program (S-CHIP)*

The Balanced Budget Act of 1997 created an expansion of children's health insurance enacted as Title XXI of the Social Security Act. Forty billion dollars in federal matching funds will be available to states over the next decade to expand coverage to uninsured children. States will be able to use this money to expand Medicaid, create new state programs for children's health insurance, or both.

Up to ten percent of a state's allotted amount can be spent on a combination of administrative costs, outreach, direct health services for children, and other health initiatives for children. The rest must be spent on health insurance, either through Medicaid or a new state program. While eligibility may vary, these new funds may be used to help only those children who are currently ineligible for Medicaid with family incomes at or below 200 percent of the federal poverty level ($32,100 a year for a family of four in 1997). Children up to age 18 can be covered, but apparently not all at once. Children are being added to the program sequentially by age.

## *The Ripple Effect of Safety Net Cuts: Health Care Personnel*

The risks to cutting safety net programs for poor children have implications for other segments of society. For instance, it is estimated that every dollar Congress or state legislatures cut from social programs will cost the nation up to $1.51 in lost future productivity—ultimately threatening the welfare of those who depend on Social Security benefits under the system currently in place. From another angle, cuts to Medicaid may threaten public hospitals—institutions that are often a community's largest employer. And the employees most affected may be women—mothers whom children depend on for economic security and stability.

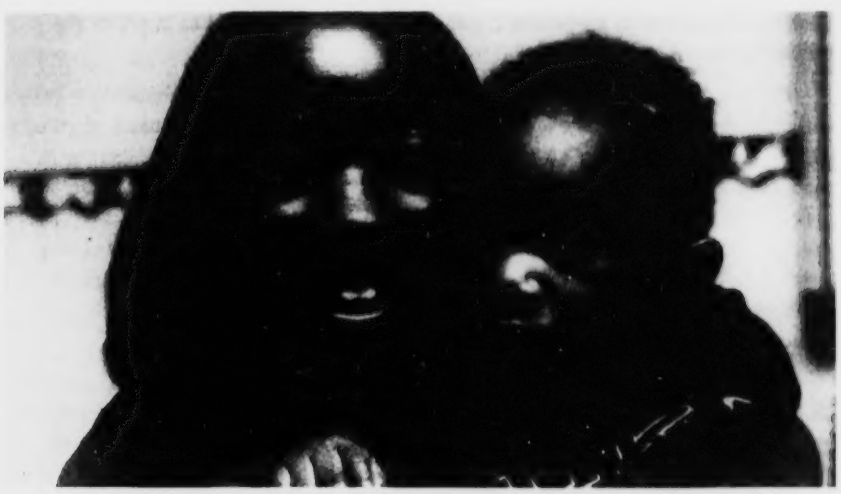
Hospital and other health system cuts exacerbate unemployment and poverty among women and African-Americans. The number of African-Americans working in medical care totals nearly 1.8 million. African-Americans account for 15.9 percent of hospital employees, but for only 5.6 percent of personnel in practitioner's offices. They hold 16.2 percent of nonmanagerial medical care jobs, but only 7.6 percent of management positions. One of every 10 employed African-American women works as an aide.

housekeeper, or food service worker in medical care, but few are health executives. Policies that shift resources from hospitals to outpatient settings and from hands-on care to administration will, unless mitigated by innovative community approaches, decrease African-American job opportunities and health coverage, and increase already high rates of poverty and attendant ill health.

Exceptions to this rule are made if, prior to June 1997, individual states provided care to children with family incomes above 150 percent of poverty ($24,075 for a family of four). States must provide matching funds to receive the funds at levels consistent with their current practices. Issues not yet resolved include whether children will receive coverage for vision and hearing services; care for children with special needs; the degree to which low-income families are protected against cost-sharing that would make care unaffordable; and whether states are required to use all of the funding for coverage of uninsured children.

Funding for the program also remains relatively static over time. This suggests that fewer children may be covered as real dollar levels decrease—and that models for care will need to be more accountable with regard to cost, scope of service, and quality.

Certainly, the new program does not suggest any departure from current medical practice that might identify and ensure treatment of the circumstances that promulgate sickness, premature death, and loss of productivity. It also does not suggest collaboration across the government and private "silos" that treat illnesses rather than the social causes that create them. The cyclical course of illness-medical intervention will likely continue as usual despite this additional coverage for children. System improvements in terms of achievement, community benefit, advancement, and productivity are not addressed.



## *Research to Support Decisions*

In 1995, the federal government invested about $2 billion—less than 3 percent of the total federal research enterprise—in research designed to help clarify factors that affect the growth and development of 30 percent of the U.S. population—the more than 80 million children and adolescents. Private foundations invested another $75 million and states and local government also funded some studies. (National Science and Technology Council, 1997)

Considering how little we know and how much we need to learn, the amount committed to gathering knowledge suggests a serious shortfall in investment. And in an era when public expenditures are increasingly based upon bottom-line thinking, credible data to support decisionmaking becomes even more crucial. Most experts would agree that we have baseline data about the depth and extent of adolescent health problems. What we need is more information about useful applications of what we know to move decisionmakers in communities, organizations, and institutions to productive action.

Research can inform us of the impact of action and inaction in social and economic programming. For example, policymakers and community decisionmakers need to know more about the factors that shape adolescent health and other social conditions. But they also need the impetus to act upon what is already widely accepted—that poverty is the most powerful force thwarting youth development; that historical, racial, and cultural practices must be amended to improve the prospects of young people.

However, having extensive data does not always result in implementing better policies, designing programs differently, or improving the health status of groups at risk. Certainly, there is an abundance of research data on factors affecting African-American child health, but health outcomes remain dismal. While research is needed to determine the extent of the issues, there must be a stronger connection between research, policy, and programming. Rather than gathering more data to substantiate the depth of our national dilemma, applied research—research that systematically examines community change practices and policies—offers more promising directions.

We know research is well disseminated in academic settings. The advancement of researchers in terms of compensation and professional recognition depends on making research available to peers in academe, funding organizations, and scholarly publications. Whether people in communities and their representatives are as well-positioned to learn about and act upon researchers' findings is less certain.

## *Measuring the Costs and Benefits of Prevention in Adolescent Health Care*

Episodic, problem-focused care is the accepted standard in adolescent health care. But figures like those shown in the table at right beg the question: Wouldn't it be less costly to invest in prevention? And the answer is: No one knows for certain.

At this point, no analysis exists of how much it might cost to deliver comprehensive primary health services to adolescents, how much might be saved in treatment costs, or what the break-even point might be. Projections have been made, but actual figures are scarce. Based on the table at right, for example, if the delivery of comprehensive adolescent health services prevented 5 to 25 percent of the treatment costs, the savings would be $1.7 to 8.4 billion. But what would the services entail, how much would they cost, and how would the actual cost be measured?

Programs such as the American Medical Association's Guidelines for Adolescent Preventive Services (GAPS) suggest savings in the amount of $5.1 billion and a reduction of 15 percent adolescent morbidity would be necessary to demonstrate a positive cost-benefit ratio between prevention and treatment. However, the GAPS figures may not adequately take into account the cost of addressing socioeconomic and cultural contexts that are correlated with adolescent risk factors. (American Medical Association, 1992; Elster and Kuznets, 1994)

Another complication to determining the actual costs and benefits of investing in adolescent prevention

is the fiscal burden it may place on insurers and purchasers initially. Although the reduction in expenses over the long term would be significant, the immediate cost might be perceived as a stumbling block.

The real question may be: How much is it worth to us to ensure the development of healthy, productive adults? Administrators in organizations and public institutions increasingly act based on the bottom-line figures. But standard ways of counting, measuring, and predicting may not evaluate the real worth of the outcome. To develop models for cost-effective adolescent prevention, not only better data, but broader thinking and figuring will be required.

## Estimated Single-Year Treatment Costs* of Selected Preventable Health Problems Among Adolescents

| Morbidity | Cost, $ | Age Range |
|---|---|---|
| Adolescent pregnancy | | |
| Abortion | 173 million | 15-19 |
| Hospital costs; low-birthweight neonates | 1.5 billion | 15-19 |
| Physician and delivery costs | | |
| Normal | 2.4 billion | 15-19 |
| Caesarean section | 752 million | |
| Sexually transmitted diseases | 882 million | 15-19 |
| Acquired immunodeficiency syndrome | 37 million | 13-19 |
| Human immunodeficiency virus | 122 million | 16-21 |
| Alcohol and other drug probems | 271 million | -- |
| Motor vehicle-related injuries (alcohol-involved only) | 13.1 billion | 10-21 |
| Unintentional injuries (excluding motor vehicle-related injuries) | 10.4 billion | 15-24 |
| Mental health problems | 3.9 billion | 10-18 |
| **Total** | **33.5 billion** | |

**in 1992 dollars*
*Source: Gans, Alexander, Chu, and Elster, 1995*

Perhaps this is related to the researchers themselves. Far too often the voices that inform policy fail to represent the growing diversity of Americans. Some policy analysts have concluded that increasing the diversity of people who conduct research and craft policy would move policy discussions in more productive directions. Whoever has control over the public discourse, they suggest, has equal control over how issues are viewed (Tollet,1993). Another avenue would be considering the orientation of the editorial boards of academic journals to ensure problem-solving versus problem-focused analysis.

At the very least, it is reasonable to conclude that research should include the voices of those engaged in meaningful problem solving to ensure that the knowledge gathered and the messages generated are valid and useful beyond the walls of academic institutions and think tanks.

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# *Promising Paths:*
## Kellogg Foundation Projects

Kellogg Foundation projects suggest promising community-based approaches to improving the health and fueling the hopes of young people. Some projects are found in urban centers, others in remote rural regions. Some provide traditional medical services, others focus on cultural traditions to reach young people. Each is unique, but they are characterized by some striking similarities as well. All identify adolescent health and well-being as a community priority; all respect the needs and capabilities of the total person within a cultural or community context; and all draw on resources in neighborhoods, within institutions, and across disciplines to invest in youth.

When young people reach this pivotal passage, they often lose faith in authority and avoid institutions or systems of any kind. Yet they are at a crossroads—a time when the physical, emotional, and cognitive changes they are experiencing are the most demanding. Support and guidance from the adults in their community can make a crucial difference in the transition to adulthood.

Traditional health systems often do little to draw those who need care most into their pathways. Programs designed to meet the health needs of adolescents require a complex array of diagnostic and preventive services—including mental health counseling, reproductive health education and treatment, and dental services. Education, career counseling, and family support can be equally important to youth in vulnerable communities. But the location of services, channels to access services, and the perceptions of young people can enable or impede delivery of services.

The projects profiled in the following pages have turned potential barriers into open doors. Their tactics for reaching teenagers—and methods of improving health status, expanding long-term prospects, and supporting the development of young people—are offered here as possible paths for other communities. The variety of their experiences is tangible proof that no one approach works for every group. Each passage, they seem to tell us, is a fresh journey. But the models grantees have developed offer markers for those traveling the same roads—and some options for communities seeking safe passages for their youth.

# Profile: TRUST (Teaching Respect, Understanding, Self-Esteem, and Togetherness) for the Development of African-American Youth, Tampa-Hillsborough Urban League, Florida

### Location:

East Tampa, Florida

### Population:

African-American boys and young men (ages 10 to 18) and their families living in the College Hill and Ponce de Leon public housing units in Belmont Heights

### Challenges:

- high rates of poverty, crime, and unemployment
- increasing numbers of young people in juvenile justice system
- untreated physical conditions and poor dental health among youth
- no health services available in neighborhoods

### Strategies:

- initiate door-to-door canvassing of apartments in the two housing projects to identify young men to participate in the program
- provide needed health services through the schools
- offer wraparound services including physical exams, health screenings, and referrals
- develop an intensive personal growth course for young men featuring African-American male instructors
- tap African-American health professionals to volunteer for health screenings

### Program features:

- primary care health screenings, follow-up testing, and treatment for adolescents and their families
- services provided by students from the University of Southern Florida Colleges of Nursing and Medicine, Hillsborough County Public Health Department, and volunteer health professionals from the Bay Area Medical Association (BAMA) and Minority Nurses' Association of Hillsborough County
- health education focused on conditions prevalent among African-Americans
- Children of the Sun School—culturally-appropriate instruction on development issues for young people
- cultural-awareness training for health care professionals and agency staff
- adult support programs
- summer youth employment program

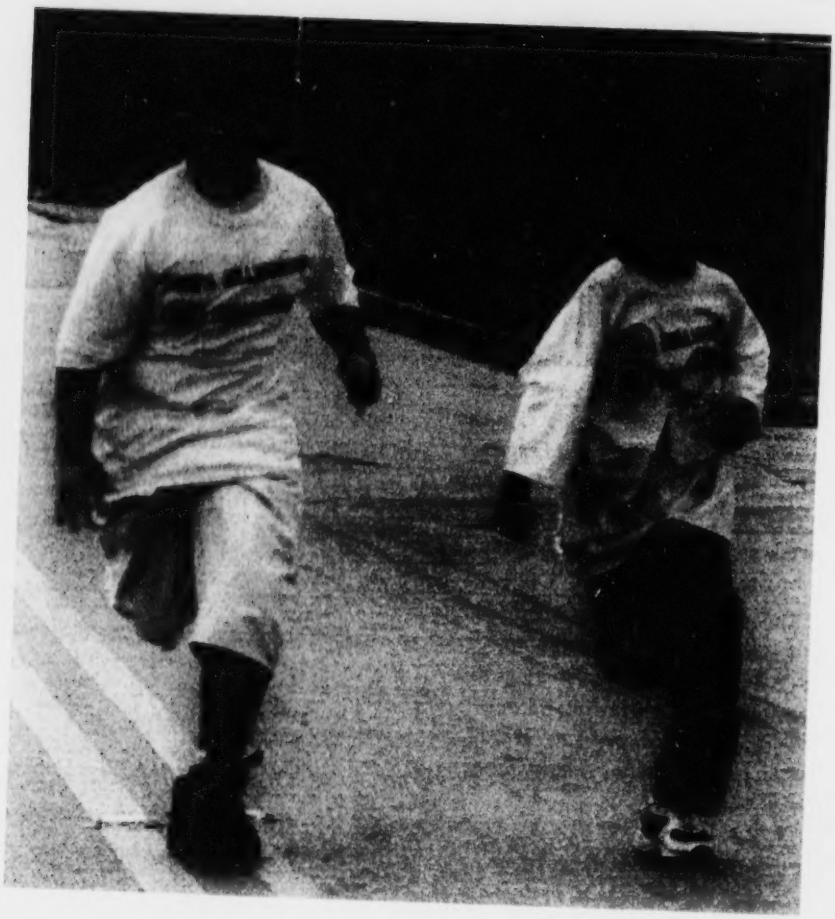
### Additional funding sources:

- Hillsborough County Public Health
- Children's Board of Hillsborough
- State Attorney General's office
- Florida state consortium on juvenile prevention
- Urban League, Inc.

### Outcomes:

- 1/2-cent county sales tax to cover health care for working people not eligible for Medicaid
- 1,500 youth physicals completed identifying conditions including high cholesterol (28 percent of young people examined), anemia (20+ percent), curvature of the spine (23 percent), and dental cavities (90+ percent)
- curriculum for 14-week youth development course
- development of health center to provide needed services
- local judges refer youthful offenders to the Trust
- parents "self-refer" young people to the program
- program expanded to include young women

# *TRUST*
## East Tampa, Florida



*"We are known for our community work. We treat the people who come to us as customers. Policymakers ought to look at community-based organizations as one of many players in delivering services where they are most needed. Community-based organizations have a role to play. They can help solve problems and deliver results."*

— *Joanna Tokley,*
*President, Tampa-Hillsborough Urban League, Inc.*

## *Project Description*

Since its inception in 1989, the Trust the for Development of African-American Youth has targeted improving the health and well-being of young men in the Belmont Heights neighborhood through culturally-sensitive recruitment, physical examinations and screenings, and health education. The Trust, a project of the Tampa-Hillsborough Urban League, Inc., has built upon the provision of needed primary health services to connect with young people and their families, coordinate services with area schools and the health department, and link with resources in the community, among health professionals, and within academic institutions. More than 400 young people each year receive physical examinations and follow-up treatment through the Trust. Of these, between 250 and 300 participate in the Children of the Sun health education program each year.

## *Greatest Impact*

Although the Trust has many successes to its credit in eight years of operations, the project's role in securing a funding stream to cover health services for local working poor is one that project leaders feel will have lasting impact on the community, its young people, and families. Tampa-Hillsborough Urban League President Joanna Tokley explains: "We were part of a larger effort including local health centers and other organizations. We worked to inform the process by sharing information about health issues and needs in our area. Our work also informed the debate about income guidelines for the program."

Trust Project Director Walter Niles adds, "The proceeds from the Hillsborough County half-cent sales tax benefit people who work, but make too much for Medicaid or other public coverage. The funds go directly to pay for services provided in a variety of health care facilities—community clinics, hospitals, and private physician offices." The development of local clinics to provide needed services—including a satellite health center office in the Belmont Heights neighborhood—is one outgrowth of the policy change.

## *Best Advice*

- The Tampa-Hillsborough Trust's experience emphasizes the importance of community buy-in. "If the community owns it, the community will support it," says Niles. Community engagement and commitment are crucial to the Trust's success. "You can't do community health programs alone," he adds. "You need to work closely with social services and other organizations."

- "You can't discriminate when asking health providers to work with you," Niles says. "You need to be willing to involve a variety of health providers—doctors, nurses, public health professionals, and others—to improve services and continuity of care." Providers don't necessarily need to be from the same culture of the people they are serving, according to Niles. But they do need to be aware of the health issues related to culture. "If we know black people are at an increased risk for heart disease, the provider needs to look closely into the patient's history, and to think in terms of cultural medical issues when providing care."

## *Long-Term Challenges*

Funding is the biggest long-term challenge the Trust and many other health programs face. But Niles identifies different challenges related to various portions of the program. "With long-term funding for the health services portion of our work, the challenge is providing for the follow-up after the screening. We have partnerships in place to manage the cost of health screening. But the follow-up needs vary and are less predictable." Dental care is another issue. Since 95 percent of the young people screened have dental care needs, Niles identifies funding for dental services as the most immediate need. "At this time, we have no health department facilities providing dental care to our young people. We need to develop a way to address this aspect of their health."

Funding an Afrocentric education program is another type of funding challenge, Niles acknowledges. "We teach from an Afrocentric perspective because we are targeting African-American young people. Some funders are uncomfortable with that—as if by embracing one aspect of a culture we are rejecting others. We serve all young people in our area—white, Latino, Asian—but our youth are predominantly African-American. We are trying to relate to their culture and lifestyle, to reach them where they are."

# Profile: Lummi Cedar Project, Bellingham, Washington

### Location:

Lummi tribal lands, seven miles northwest of Bellingham, Washington

### Population:

Lummi children, youth, and their families

### Challenges:

- teen involvement in gangs
- substance abuse and smoking among young people
- youth ignorance about traditional ways; rejection by some
- difficulty of retaining, revitalizing culture in the midst of media and other influences
- poor health choices and low motivation among youth on reservation

### Strategies:

- promote well-being by integrating traditional Native American and mainstream approaches
- work through culture and community to foster health improvement and youth development
- involve community members of all ages in health promotion and education efforts
- focus on traditional team sport of war canoe racing—canoe pulling—to motivate young people and community members

### Program features:

- conditioning and training to increase youth involvement in sport of canoe pulling
- participation in canoe pulling competition throughout the region and nationally
- community focus on traditional activities to support athletes, such as fundraising and dedication of a new 11-person canoe to add to the fleet
- water safety, CPR, and first aid instruction for community members, especially canoe pullers, skippers, and coaches
- ongoing education about diseases and other conditions that threaten community health and well-being including HIV/AIDS, substance and alcohol dependence, smoking, and consumption of processed foods

### Additional funding sources:

- Community-Based Public Health partners including Seattle Urban Health Alliance
- Whatcom County Public Health Department
- Portland Area Health Board
- Lummi fundraising efforts

### Outcomes:

- 501c(3) status to continue program
- increased participation in sport (up to 70 canoe pullers)
- commitment to healthy lifestyle for young people participating in sport
- HIV/AIDS peer training and workshops
- deepening of cultural traditions among community members of all ages
- ongoing health education activities including health fairs and annual conferences
- youth and adult participation in swimming lessons, CPR, first aid training and other related activities

# *Lummi Cedar Project*
## Bellingham, Washington

*"Cedar is sacred to the Lummi people. Our baskets are woven of cedar, canoes are carved from it, our log homes are built from it."*

— *Vernell Lane,*
*Site Coordinator, Lummi Cedar Project, Group Health Cooperative, Puget Sound*

## *Project Description*

The Lummi Cedar Project draws on the rich tradition of the Northwest coastal tribes in its approach to youth development and health improvement. One of seven consortia in the Washington Community-Based Public Health Initiative, Lummi Cedar Project efforts are part of a larger commitment to improving public health education by linking the training of health professionals with the needs of underserved communities. The Lummi Cedar Project identifies four goals for improving community health—each founded on traditional values: (1) a commitment to strenuous physical exercise; (2) a healthy diet based on traditional rather than processed foods; (3) a drug-free community; and (4) limiting sexual activity to times when it is appropriate.

Lummi have always lived near the sea. For hundreds of years the canoe was not only vital to survival, but a symbol of the endurance, skill, and dignity of a people. Canoes allowed the Lummi to fish, gather food, trade, and travel. And through the sport of canoe pulling in years past, the Lummi people blended physical strength, teamwork, and determination to successfully compete with other nations. In canoe pulling today, the Lummi Cedar Project has identified a mechanism for promoting health, engaging youth, drawing on community strengths, and deepening cultural relevance to present-day challenges.

## *Greatest Impact*

Vernell Lane, site coordinator for the Lummi Cedar Project, says the renaissance of canoe pulling among the Lummi people is an area of significant impact. "We almost lost it," she says of the sport. "But today our people—men and women, boys and girls, old and young—are involved in the tradition. The legacy is alive and linking our young people with their Lummi ancestors."

Lane explains the connection between canoe pulling and health: "When you decide to pull canoe, you've got to lead yourself into a healthy lifestyle. You can't drink or smoke. You abstain from sex. You also avoid coffee, pop, and foods high in sugar. It is rigorous physical activity." Canoe pulling also communicates spir-

itual values and aspects of identity to Lummi youth. "All things have life in the spirit," Lane says of Lummi beliefs. "The canoe is a spiritual vessel, an object of great respect—from its life as a tree, falling to earth as a log, and finally, landing on the beach as a finished craft." Canoe pulling relates Lummi youth to the tribal connection between land, water, and sky. Preserving and revitalizing this tradition, Lane says, has made the canoe "a healing vessel" for Lummi people.

## *Best Advice*

- Lummi Cedar Project experience advocates building on the culture and traditions of the community to craft health improvement approaches. Says Lane, "In a world of mortgages and deadlines, it can be difficult to have faith in spiritual and cultural values." But the advantages are many, as the Lummi Cedar Project has shown. Steeping Lummi Cedar Project health improvement strategies in tribal traditions has strengthened the entire community and given an intergenerational dimension to addressing adolescent health issues. "For many of our people," Lane explains, "the canoe is an important physical symbol for the relevance of the ways of our ancestors."

## *Long-Term Challenges*

The greatest challenge the Lummi Cedar Project faces is ensuring that the tradition continues to flourish in future generations. "Canoe pulling symbolizes the cultural recognition of many nations as they struggle to retain and rebuild following a period of systematic oppression and rapid social and technological change," Lane states. "Will our children understand its importance and practice our traditions so our grandchildren will have them?" That remains to be seen, she acknowledges. But the Lummi Cedar Project is putting its faith in the tradition of the canoe. "They say all the knowledge for building the canoe is within the tree itself. Perhaps some of the lessons for our people are held within the canoe or the journey of the canoe. . . . Where it will take us, we cannot see. But the canoe will continue to guide us."

## Profile: Adolescent Family Life Program, La Clinica de Familia, Inc., Sunland Park, New Mexico

### Location:

Gadsden School District in southern New Mexico near the borders of Texas and Mexico—the largest school district in the state located in one of the ten poorest counties in the U.S.

### Population:

Pregnant and parenting adolescents and their families in a primarily Hispanic (81percent) community of 75,000

### Challenges:

- replicating successful urban program for pregnant and parenting teens (La Clinica de Familia, Inc., Las Cruces, New Mexico) in border town setting
- high rate of poverty
- lack of health services
- unequal distribution of resources for education (significantly lower reimbursement per student in Gadsden—one-third the amount per student of Santa Fe rate)
- cost-cutting climate in state ($800,000 cut to state schools creating $2.4 million gap with match)
- fear of INS response if young girls seek services
- difficulty recruiting people to work in New Mexico (because health and human service professionals are paid much more in Texas)
- lack of transportation

### Strategies:

- solicit direct referrals from schools to identify pregnant and parenting young people
- connect with hard-to-reach individuals through promotores
- initiate home visits and active outreach to generate positive word-of-mouth referrals
- maintain a bilingual, bicultural staff of people from community
- work with health professions schools and anthropology departments including the University of New Mexico, New Mexico State University, and University of Texas at El Paso

### Program features:

- school-based and community counseling and case management
- job placement, resume writing, and interview skill development
- education of health professions students
- parenting and prenatal care
- reproductive health education including parenting, prenatal, and newborn care
- referrals for GED classes

### Additional Funding Sources:

- Gadsden School District
- employers in Sunland Park, Anthony, and El Paso
- community colleges in Texas and New Mexico
- public health department
- labor department

### Outcomes:

- provision of wraparound services for pregnant and parenting teens
- collaboration with agencies serving teens
- coordination of limited resources
- 183 young people served in Sunland Park facility in 1996 (142 young women; 41 male partners)

# *Adolescent Family Life Program*
## Sunland Park, New Mexico

*"Another thing that complicates what we're doing is that pregnant girls aren't seeking medical or social services because they are afraid of being turned in as illegal aliens. We are told that some residents of Sunland Park are afraid of going to the post office. Unfortunately, some fears are real, but we could tap into some resources for them. We're trying to work through the promotoras to dispel myths."*

— *Suzan Gonzalez,*
*Medical Program Director*

## *Project Description*

The Adolescent Family Life Program in Sunland Park, New Mexico, is an outgrowth of the successful La Clinica de Familia program in urban Las Cruces. A comprehensive health and education program for pregnant and parenting teens, the Adolescent Family Life Program is focused on keeping young women in school by addressing their medical, physical, and emotional needs during and after pregnancy. Working through the public schools and with the assistance of community promotoras, the family-centered, community-based program has been able to reach a significant number of pregnant teens in its first few years of operations.

## *Greatest Impact*

The program's dedication to providing wraparound services has yielded the greatest impact, according to project leaders. "We are able to link our clients to the resources that are available in the county," Adolescent Family Life Program Director Kelly Stagen says. "Although our approach is family-oriented, the one-on-one problem solving we do with young people—and the service plan we develop with each—is how we improve individual lives."

Stagen and Medical Program Director Suzan Gonzalez agree that keeping students in school and helping them make a transition to a new role, a new life is part of the program's impact. "We help bridge the gap by teaching them how to wear two hats," Gonzalez and Stagen say.

## *Best Advice*

- Adolescent Family Life Program decisionmakers encourage others implementing projects to spend time on evaluation in the planning phase. Stagen states: "Have your evaluation tool up front from the beginning. If you have it at the outset, you will have identified what it is the project must accomplish and the direction you need to move. With a good evaluation tool, you will know if project efforts are showing results—or if they are getting off track." Attention to evaluation will also lay the groundwork for data collection, outcomes analysis, and long-term planning.

## *Long-Term Challenges*

Stagen identifies transportation as the biggest long-term challenge for the program. "It's rare that our clients have access to transportation—and when they do it is not always reliable," she says. "Plus, there is no public transportation in the area and no plan for it in the future." In a rural region with very few resources, she explains, transportation becomes a major issue.

Gonzalez adds that the issue of transportation has taken on a new sense of urgency since New Mexico made the transition to Medicaid managed care. "You can see Texas from our clinic—it's across the street. But the young women we see—adolescents expecting a first baby—will need to travel 45 minutes into Las Cruces to have a prescription filled or enter a hospital when they go into labor. Under the terms of New Mexico's Medicaid managed care, Texas hospitals and other providers are off limits."

The designers of managed care do not seem to have considered border town issues, Gonzalez says. "Mexico is a mile away and many clients have prescriptions filled there because it's cheaper. Managed care allows 15 minutes for appointments. But it might take 15 minutes to look up an unfamiliar drug in the Spanish PDR."

Another challenge unique to providing services in a border town is the difficulty of attracting and retaining staff. "Keeping staff is a major problem," Gonzalez says. "Nurses and other providers only need to go a few blocks into Texas to increase their salaries by $5,000 or more. Maintaining continuity in our staff continues to present a significant challenge."

## Profile: Center for Black Women's Wellness, Atlanta, Georgia

**Location:**

Mechanicsville, a community in metropolitan Atlanta

**Challenges:**

- generally poor health of African-American women regardless of economic status
- limited access/use of health facilities
- limited services beyond childbearing
- use of emergency room for primary health services
- high rates of poverty
- lack of education and job training

**Strategies:**

- use marketing approaches to engage community members in decision making
- provide a broad range of services that promote physical, mental, and spiritual wellness
- target the parents of teenagers and community adults to address adolescent sexuality and health issues
- teach through parents and adults who understand that youth are sexually active and need to be protected

**Program features:**

- Plain Talk, a teen pregnancy prevention and sex education discussion program
- health screening, assessment, and education
- GED and employment education
- micro-enterprise program
- summer youth leadership program

**Additional funding sources:**

- city and state level investments
- other private foundations
- federal grants

**Outcomes:**

- increased community participation in focus groups, surveys, and other issue-focused activities
- increased use of center facilities for education, self-help groups, and health screening (more than 1,500 patron visits in 1996)
- collaboration with area health and human service agencies

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# *Center for Black Women's Wellness*
## Atlanta, Georgia

*"We must change how adults relate to young people. Adults should seek information and services on behalf of their children. That's the only way we'll see change. If you can change the head of the household, you can change a generation. The ripple effect on the whole family creates systemic change."*

— *Cheryl Boykins,*
*President/CEO,*
*Center for Black Women's Wellness*

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## *Project Description*

The Center for Black Women's Wellness is a community-based, self-help center dedicated to improving the mental, physical, and spiritual growth of women and their families, and the economic growth of communities. Since 1988, the Center has expanded upon a broad definition of health and collaboration with other institutions to offer a growing array of services including traditional health screening, assessment, and referral; health and self-care education focused on prevention; basic education and GED preparation; vocational skills and computer training; self-help group development; and teen pregnancy prevention.

## *Greatest Impact*

The Center's impact can be seen on two levels, according to President and CEO Cheryl Boykins. "The community ownership has been an important area of impact," she explains. "We're in southwest Atlanta near downtown and our area is a mixture of a highly transient population and families who have lived here for generations. In almost ten years of service, we've seen a real change in the willingness of people to be engaged in issues that affect them—and be a part of the solution. The increasing numbers of people involved in meetings, surveys, and focus groups tell us that we are having impact. Over time, we've built a reputation as a credible source of services, information, and education."

On another level, Boykins says the coalition-building the Center fostered has resulted in more coordinated services and better communication among agencies serving the same population. "We have partnerships with the Fulton County Health Department, Grady Memorial Hospital Teen Services Division, the City of Atlanta Parks and Recreation Department, South Side Health Center, and others. By coordinating services, the Center is working to improve the quality of services and cut red tape for the people we see. But we're also trying to shape how people use the system—how they interact with it—so it can do more for them."

## *Best Advice*

- Boykins and her colleagues agree that the community needs to define the issues. "Engage the community first," she emphasizes, "not when you've already decided what to do. Ask if something is an issue—and if it's an issue community people want to address. If you want to deal with a particular issue, but people don't want to tackle it, you're wasting your time. Focus on issues of importance to the community and build from there."
- The Center has used marketing approaches—surveys and focus groups—to engage people in planning and implementation. "We do a lot with focus groups," Boykins says. "But we do as they do in marketing firms—we recognize people for their time and expertise. Some organizations say it's hard

to get people to actively share what they know. But if you want people's thinking on community issues, you need to reward it accordingly." The Center has also cultivated the people they connect with through focus groups, Boykins adds. Some have trained to conduct surveys at special events. "That builds ownership, too," she says.

## *Long-Term Challenges*

"Our greatest challenge is to figure out a way to make our patrons into investors in our program to ensure sustainability," Boykins believes. "Our patrons must be the foundation of our services so we will not continue to rely on others for survival. We are working to develop the Center as a viable organization where the services offered generate income and contribute to sustainability."

This challenge is part of a larger balance issue Boykins feels many community-based organizations face. "Organizations located within the community are often community-based, but not always community-driven," she suggests. "Community-driven means issues are voiced by community people; programs and services are determined by community interests; and the organization is sustained and supported by community participation and resources."

# Profile: The Corner Health Center, Ypsilanti, Michigan

### Location:

Ypsilanti, a medium-sized Michigan town eight miles east of Ann Arbor

### Challenges:

- lack of medical care for young people in 1980
- high rate of teen pregnancy (5.7 times that of Ann Arbor)
- high rate of infant mortality (60 percent higher)
- county human services located in neighboring Ann Arbor
- high percentage of low-income residents compared with nearby communities
- inadequate public transportation to services

### Strategies:

- locate in community education building
- provide services to youth 12 to 21 and their children
- offer "one-stop" comprehensive, integrated medical services including obstetric and pediatric care, plus counseling, educational support, peer education, and human service access through one facility
- work with health professions education institutions to offer a wide range of health services

### Program features:

- obstetric, pediatric, family planning and other medical services
- access to human services including the Women, Infants and Children (WIC), Maternal Support Services (MSS), and Infant Support Services (ISS) programs
- HIV counseling and testing
- health professions education
- peer educators trained to offer pregnancy prevention education and assist in lab work
- youth theater troupe performing skits that deliver prevention messages related to substance abuse, sexually-transmitted diseases, HIV/AIDS, and violence prevention

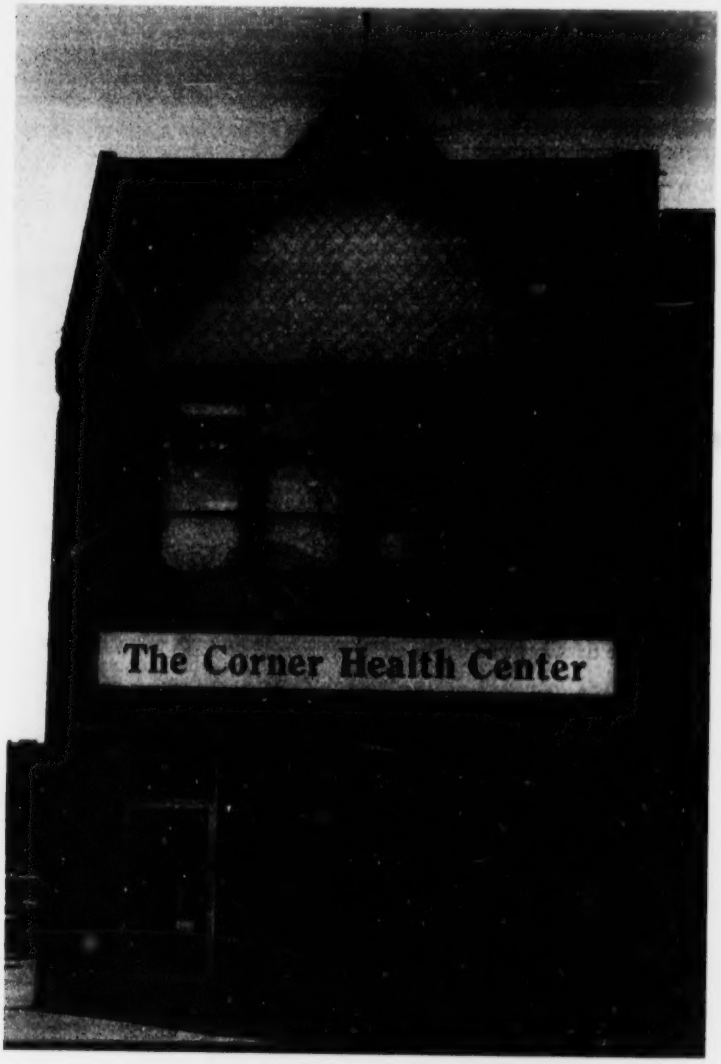
### Additional funding sources:

- government grants
- other private foundations
- in-kind donations
- fee-for-service revenues
- United Way
- civic and religious groups
- local businesses and concerned individuals

### Outcomes:

- decrease in teen birth rate (declined by 56 percent in Ypsilanti)
- no very-low-birthrate babies born to Corner patients
- Caesarean birth rate of only 12 percent
- average weight gain in pregnancy of 30 pounds
- 1,000 family planning and 150 maternity patients per year
- WIC services to 700 teen mothers and their children each month
- 100 adolescents and health professional trainees oriented
- development of extensive curriculum materials for medical residents and other health professions students working at The Corner

# *The Corner Health Center*
## Ypsilanti, Michigan

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*"We see decisions being made on the basis of administrative convenience and ease rather than if it benefits the client. In recent months, our patient load has changed as patients are being directly enrolled in HMOs. But we find the people are not being referred. We're losing Medicaid patients and keeping the ones with no way to pay for services. We're engaged in strategic planning, focusing on what it will take to stay afloat and who we need to float with."*

— *Dr. Joan Chesler,*
*Executive Director*

## *Program Description*

Since opening its doors in 1981, The Corner Health Center has filled a health care gap for young people in southeastern Michigan. From an annual budget of $11,500 its first year, "The Corner," as it is called by patrons and staff alike, has grown to an organization providing a wide range of health and human services with an annual budget of $1 million. In 16 years of operations, The Corner has changed in size and its growth has prompted more than one change of location. But the premise it was founded upon—providing needed health services to young people ages 12 to 21 and their children under a single roof—remains intact. The effectiveness of this approach has been documented by data showing improved health outcomes and a steady increase in the demand for services.

In the course of its work with young people, The Corner has explored numerous ways to connect with adolescents and involve them in decision making and education. This commitment to serving and engaging clients has led to development of The Corner Theatre Troupe and a successful peer health educator program. Both efforts are part of The Corner's focus on prevention.

## *Greatest Impact*

Measurable health improvement among teenage mothers and their children is one area of great impact as a result of The Corner's work with young people. In 1976, a task force charged with providing recommendations to reduce teen pregnancy in Ann Arbor, Michigan, compiled needed health data. The data pointed to an increasing teen birth rate and high rates of infant mortality and morbidity among babies born to teen mothers in neighboring Ypsilanti. The data became the springboard for community action.

Pooling the resources of local public schools, the community action agency, local government, public human service agencies, and the obstetrics and gynecology department of the University of Michigan, local leaders began to conceptualize a comprehensive health care center for teenagers. Although the path to founding The Corner was a long and, at times, rocky one, the improved health among childbearing teens and the collaboration across service areas that contributed to this achievement continue to contribute to the well-being of youth in the region.

## *Best Advice*

- The Corner's experience supports the wisdom of a "one-stop" approach to providing services to young people—and a willingness to respond to identified needs. Originally housed in a local community education building and offering only two afternoon clinics a week, the response to The Corner's services required steady growth from its earliest days of operations. But from the beginning, expanded services were based on issues identified by clients. For instance, in the early 1980s, a social worker providing in-kind services through the University Women's Hospital identified some additional

counseling needs at postnatal hospital visits. Most hospital patients, when asked how they were, said "fine," she explained. Corner patients were more direct. The Corner continues to ask questions of clients and listen to their answers.

## *Long-Term Challenges*

Continuing to provide comprehensive, integrated services to young people given the current market-driven health care climate presents the greatest challenge to Corner decisionmakers and advocates. The introduction of Medicaid managed care in mid-1996 has shifted Corner approaches to long-term sustainability. But this change prompts questions for those who provide comprehensive health services to underserved populations, according to Dr. Joan Chesler, who has served as the program's executive director since its inception in 1980. "Will these managed care systems translate into improved health care? No, quite the contrary," she says. "If you're looking to increase the bottom line and you know you will lose money on Medicaid, your only option is to decrease services. . . . But the market focus is likely to prevail. It gives state agencies predictable budgets because risk will be assumed by the HMOs. This approach doesn't have much to do with patient care. But it has everything to do with money management."

## Profile: Boys, Girls, Adults Community Development Center (BGACDC), Inc., Marvell, Arkansas

### Location:

Marvell School District in the northwest quadrant of southeast Arkansas, population approximately 5,500

### Population:

Residents of the City of Marvell and 12 unincorporated communities of which 53 percent are African-American and 46 percent white

### Challenges:

- no medical doctor in Marvell (located 20 miles from nearest health care facility)
- high rates of teen pregnancy, STDs, infant mortality, substance abuse
- high rates of poverty, unemployment
- low rates of immunization prior to 1985

### Strategies:

- holistic approach to youth development and community health improvement encompassing housing, employment, and related issues
- collaboration with University of Arkansas Medical School, Arkansas Health Department, City of Marvell, and Marvell School District

### Program features:

- preschool education and day care
- full range of parenting programs targeting different age groups
- summer day camp and Saturday activity program at youth center
- intergenerational program linking seniors at housing complex with youth

### Additional funding sources:

- county and state agencies
- state arts council
- income generated by commercial projects

### Outcomes:

- Marvell Medical Center opened in 1996
- very high immunization rate (nearly 100 percent) among children entering kindergarten
- collaboration with four-county workforce alliance
- participation in welfare reform task forces at the state and local levels
- multiple commercial ventures (low-income housing complex, laundromat, day care center, restaurant)

# *Boys, Girls, Adults Community Development Center, Inc.*, Marvell, Arkansas

*"BGACDC doesn't look at health care as medical care only. When we think of children, we think of doing things like a parent would. Everything we do is centered on children, but we have to look at housing, economic development, and education to be able to take care of our children."*

— *Beatrice Clark-Shelby,*
*Executive Director, BGACDC, Inc.*

## *Project Description*

The Boys, Girls, Adults Community Development Center (BGACDC) describes itself as an organization helping people build new lives, hopes, and dreams. Founded in a small Delta town in 1978 by parents coming together for their children, BGACDC represents a strong grassroots organization that nurtures families, draws on the strengths of adults and elders, and challenges and encourages young people. BGACDC's holistic approach to health and development includes extensive programming and economic development initiatives—such as the Center's restaurant, laundromat, and 39-unit multifamily housing development.

Programs include PREP (Pre-stepping for Success) for children ages 6 and 7; GAG (Girls are Girls) for young women at risk of school failure and teen pregnancy; and DAD (Dealing with Adolescent Development), a program targeting young African-American males. Additional services include day care, after-school care, and job training. To foster development of BGACDC initiatives, the Center partners with school districts, the health department, churches, local governments, health care providers, a four-county workforce alliance, arts organizations, and county extension services.

## *Greatest Impact*

Perhaps the greatest impact of BGACDC's operations has been its role in securing local health services for the people of Marvell. Prior to the opening of the Marvell Medical Center in 1997, medical practitioners were infrequent visitors to the area. Although BGACDC operated a satellite unit in conjunction with the county health department, pediatric care was available only one or two days a month, and regular primary care services entailed a 40-mile round trip.

BGACDC surveyed residents, identified health issues and unmet needs, and voiced the medical concerns of Marvell residents young and old. Contacts with young families and elders, men and women, children and teens through BGACDC programs and projects made it possible for the Center to assume an active role in the process. One measure of the level of community commitment to securing local medical care: Citizens of Marvell contributed $40,000 toward the Marvell Medical Center—most of that coming from individual family contributions of $100.

## *Best Advice*

- Beatrice Clark-Shelby, Executive Director of BGACDC, advises projects to begin looking at policy issues that affect long-term goals at the beginning of project efforts. "We don't feel we put time in on policy issues at first. We didn't know how," she says. But her advice to others: "Look at the impact of policy from year one." Today, BGACDC advocates assuming a voice on issues that can improve the larger environment. "As a community voice, we do impact state and local issues," BGACDC Planner and Developer Annie Huff explains. "We are vocal about the desires and aspirations of people in our community. We've played a role in city deliberations, on state-level review

boards, in school district discussions, and on welfare reform task forces." Building local capacity, BGACDC leaders say, is essential for sustaining project efforts.

- BGACDC leaders also emphasize the importance of treating the project like a business from its inception. They suggest identifying skills and assets the project needs to sustain operational growth through a continuous process of planning and evaluation. For instance, projects often need specialized skills to accomplish their goals. "As much as you want to develop people," Clark-Shelby says, "projects cannot afford long periods of training. . . . There is no substitute for knowledge." Identify skills, BGACDC advises, and hire accordingly.

## *Long-Term Challenges*

Although BGACDC has been successful in youth programming, community organization, economic development, and securing a mechanism for delivery of medical services locally, self-sustainability has eluded project efforts to date. But self-sustainability remains the project's top priority and greatest challenge. "We have been successful in leveraging financial support from government agencies and private funders," Huff and Clark-Shelby agree. "But we need to generate a greater percentage of our resources to make sure we can continue and grow."

## Profile: Boston Unites to Raise Its Children, Center for Community Health, Education, Research, and Service (CCHERS), Boston, Massachusetts

### Location:

Health Careers Academy, a pilot "school-within-a-school" at Dorchester and Boston High Schools in Boston, Massachusetts

### Population:

Public school students and their families from Boston's urban core, including African-American and Latino youth

### Challenges:

- high rates of unemployment, drug use, and violence in students' communities
- systemwide low student achievement, lack of motivation
- underrepresentation of minorities in health careers
- getting students interested in health careers
- getting CCHERS partners to commit to creating and maintaining an educational pipeline for young people
- space for classes
- scheduling logistics

### Strategies:

- foster collaboration between business, higher education, and public schools
- connect student's family with the education process
- pilot "school-within-a-school" concept as a model cluster school focused on preparation for health careers
- integrate academic focus with future employment
- link with middle school to prepare students and families for the Health Careers Academy earlier

### Program features:

- expanded curriculum that integrates health and health careers content into academic disciplines
- practical experience in health care settings as part of curriculum
- health services on site for students
- health career exploration through community service and internships
- mentoring
- significant after-school academic support through tutoring, study groups, and workshops
- summer work program
- student and family support through student services coordinators and academic counselors
- active parental involvement in the student's educational plan

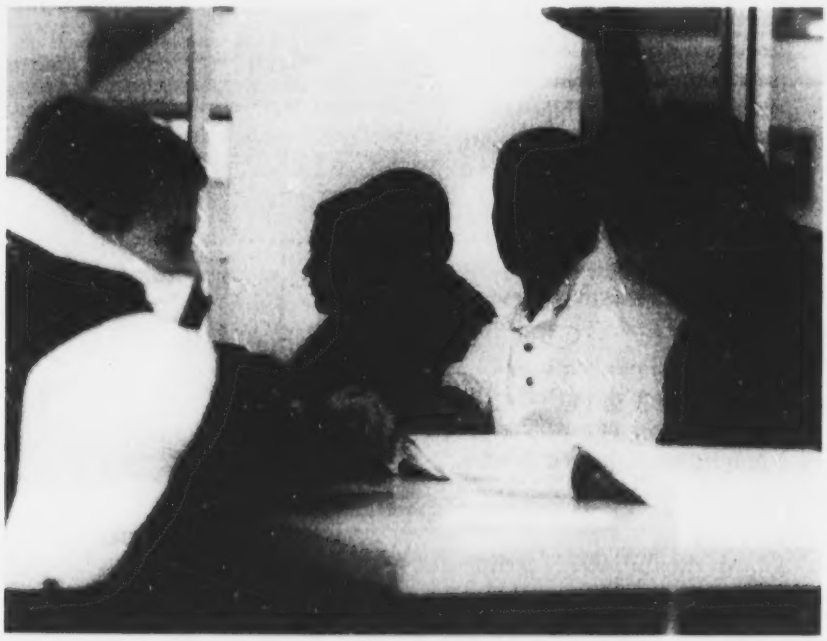
### Additional funding sources:

- donations and local church support
- fundraising projects
- Northeastern University, Boston Medical Center, and Partners Health Care System
- Boston Public Schools
- Annenburg Challenge Fund, Hayden Foundation

### Outcomes:

- viable model for linking university to public education
- improved student attendance
- higher test scores than public school peers
- increase in number of students electing to attend the Health Careers Academy
- student governance council involved in school's decision-making process
- advisory board that includes parents and diverse community interests
- greater participation and collaboration among business and higher education partners
- expanded programming for families, including Spanish-language GED classes
- welfare-to-work model
- Horace Mann Charter School status

# *Boston Unites to Raise Its Children*
## Boston, Massachusetts



*"Health care is the leading industry in the greater Boston area. Our students live in the shadows of major teaching hospitals. Our challenge is getting them to aspire to be working inside those walls."*

— *Elmer Freeman,*
*Executive Director, CCHERS*

## *Project Description*

Boston Unites to Raise its Children is rooted in approaches that join the resources of communities and institutions to solve complex problems. As early as 1990, a Kellogg-funded program called Healthy Transitions/Healthy Futures was targeting the well-being and education of adolescents at Boston High. The experience from providing on-site health services, wraparound family support, mentoring, and health careers curriculum was the basis for the Health Careers Academy. And CCHERS, the organization that operates the Health Careers Academy, was one of seven Kellogg Foundation Community Partnerships with Health Professions Education projects targeting the education of primary health care professionals in out-of-hospital settings. CCHERS continues its work as part of the Graduate Medical and Nursing Initiative today. CCHERS brought extensive insight to the challenge of drawing academe, business, and health systems into a working partnership. The Health Careers Academy's advances in only three years of operations reflect the diligent efforts and insight of these groundbreaking projects.

Today the Health Careers Academy has 160 students in ninth, tenth, and eleventh grades at two campuses in Boston. Working with and through the Boston Public Schools, Northeastern University, and a network of community health centers, the Academy is educating young people, touching their families, and changing the way health professions education institutions and health systems build the pipeline for the workforce of the future.

## *Greatest Impact*

CCHERS Executive Director Elmer Freeman sees educational policy and system reform as the areas of greatest impact to date. "On one level, the curriculum developed for the Health Careers Academy is being reviewed by the school system," Freeman says. "It may serve as a model for use elsewhere in the Boston Public Schools system. Some of the computer applications and community health needs assessments that are part of our students' education may be implemented in other programs." In health professions education, the changes may be more subtle, but just as significant, Freeman thinks. "At the university level, decision-makers are looking at admissions criteria and the possibility of giving priority to applicants from our neighborhoods. After all, our students are neighborhood kids. The Health Careers Academy hopes to extend the Northeastern University cooperative education model to the high school level. Through CCHERS, undergraduate and graduate-level health professions students and Health Careers Academy students are learning and working in neighborhood community health centers. The connection is becoming more clear."

The other area of tremendous impact is in individual students' lives, explains Freeman. "Students elect to come to the Health Careers Academy. We tell them and their parents that the expectations will be different, but what they gain will be significant," Freeman states. "The way the students grow from striving and achieving is obvious. When the student governance council representatives participated in interviews to select a new administrator recently, I watched to see if they'd be intimidated by the adults on the search committee. But they held their own and pursued their interests with great determination. That's a measure of esteem."

## *Best Advice*

- Freeman advocates tenacity when dealing with partners and keeping your focus realistic. "You need to get interested, committed partners to the table. But you also need to recognize that this is a process, not an event," he says. "You need 'stick-to-it-iveness' to keep it going. And you need to recognize the needs of the partners and the realities of the situation. We have to acknowledge that all these students are not going to college—all of them are not going to Northeastern. But our objective is to encourage students to reach for higher levels of achievement. So we cultivate opportunities in biotech and other health-related fields and work closely with Northeastern University as a partner at the same time."
- "Look for ways to make schools part of the community at large," Freeman offers. "Schools in neighborhoods are used for very limited hours. But students and their families live close by and have needs and interests that may not fit into traditional school hours. We are a pilot school, so we are exempt from some educational 'red tape,'" he admits. But even with the traditional barriers of educational policy and practice in place, the Health Careers Academy's experience suggests it is worth the effort to identify ways to bring institutions closer to the needs of communities.

## *Long-Term Challenges*

As one of nine pilot schools in the Boston system, Freeman thinks sustainability is the biggest long-term challenge for the program. "The school department sees us as health professionals, not necessarily as educators or educational administrators," Freeman says. "We have the challenge of demonstrating the efficacy of the model and making sure it is applicable to the broader school population. But we are smaller, more direct, more connected to families in our model. So our results are going to be different," he states. "We approach parents as partners. That's something most school systems have a hard time doing. We do home visits and have the funding to extend our reach to make certain we connect with families. The challenge will be to create something that can be replicated in other systems. Hopefully, we are using the resources we have now to find approaches and ways of implementing them that will help educate more young people for future opportunities."

## Profile: New Chance, Manpower Demonstration Research Corporation, Detroit, Michigan; Allentown, Pennsylvania; Lexington, Kentucky

**Location:**

Detroit, Michigan; Allentown, Pennsylvania; and Lexington, Kentucky

**Population:**

Teen mothers receiving welfare and their children

**Challenges:**

- document successful strategies for improving the health and well-being of teen mothers
- increase the employability and self-sufficiency of young women receiving welfare
- enhance the development of participants' preschool children

**Strategies:**

- offer a complete range of educational services to program participants
- one-stop-shopping approach for services to teen mothers
- track progress across different projects and compile findings

**Program features:**

- day care
- medical screening and health services
- education for GED or vocational training
- reading instruction
- parenting skill development and support
- family planning education
- case management services

**Additional funding sources:**

- government grants
- in-kind support from health professions institutions
- job training funds
- fee-for-service revenues

**Outcomes:**

- identified the range and extent of challenges facing teenage mothers entering the workforce
- fostered successful partnerships in very different communities
- increased reading and employment levels of participants

# *New Chance*, Detroit, Michigan; Allentown, Pennsylvania; and Lexington, Kentucky

*"What works for a 19-year-old is vastly different than what works for a 16-year-old."*

— *Cathy Liesman,*
*Deputy Director, New Chance, Development Centers, Inc., Detroit*

*"You need patience to do this work. You don't always see results right away."*

— *Cathy Zuk,*
*Director, Expectant and Parenting Youth Program, Allentown*

*"We've had success with anything we can put under our roof."*

— *Jean Sabharwal,*
*The Family Care Center, Lexington*

## *Project Description*

New Chance, a national research and demonstration program, was designed to provide information about the behavior of young mothers receiving welfare, the problems they face, and their efforts to move toward self-sufficiency. New Chance programs offered an array of services, but were grounded in education. The 16 programs operating in 10 states provided academic and vocational skills to move young women into the workforce, and parenting and interpersonal skills to improve relationships and the quality of decision making. The New Chance model also focused on improving the cognitive, social, and physical development of participants' children. New Chance was conducted between 1989 and 1992. Twelve of the 16 sites continue operations.

The sites in Allentown, Pennsylvania, Detroit, Michigan, and Lexington, Kentucky were funded in part by the Kellogg Foundation. The parent organizations of the three projects reflect the range of community champions interested in easing teenage mothers into the workforce.

The Expectant and Parenting Youth Program in Allentown is part of the Private Industry Council of Lehigh Valley—an employment and training organization.

The Teen Parent/New Chance Program in Detroit is affiliated with Development Centers, Inc.—a private, nonprofit behavioral health care agency.

The Family Care Center in Lexington is a project of the Lexington-Fayette Urban County Government.

All include the model's key components: day care, education for the young women, and case management of other health needs. And all three continue to provide services to young women and their children today.

The New Chance demonstration hoped to document what it would take to give young women on welfare a foothold in the job market. In the final report, completed in 1997, data indicated that preparing young mothers on public assistance for self-sufficiency was far more complex and time-consuming than current policy suggests. Some key findings:

Homelessness, domestic violence, child care and transportation problems, illness—all constrain the prospects of young women in this population no matter how high the level of motivation.

In general, sites reported that the level and extent of needs among participants was not anticipated. Very low reading levels, problems with substance abuse, unstable living arrangements, and other issues combined with adolescent short-term thinking and impulsive behavior made acquisition of job skills an uphill battle.

New Chance data indicated that the rate of job-holding among participants was high. But rates of job loss were equally high and frequent job changes were common. Job turnover, the New Chance experience suggests, may make self-sufficiency within only a few years unlikely.

## *Greatest Impact*

The Allentown staff point to the increase in GED attainment and employment as the greatest impact of the project. In 1996, 86 percent of participants received their GED and 56 percent entered the workforce.

Cathy Liesman, Deputy Director of the Detroit New Chance programs, says the greatest impact of the project is seen in individual participants' lives. "People do move from dependence to independence," she says. "Our greatest impact is seen in helping clients plan beyond the next day—helping them develop life goals and learn how to get the resources they need on their own."

Jean Sabharwal of The Family Care Center in Lexington considers the decrease in repeat pregnancies—from 40 percent within 18 months to around 8 percent—and the improved parenting skills as the most significant areas of impact. "We will hear back from young women two or three years after they've participated in the program," Sabharwal says. "They will refer to something they learned in the program—selecting good child care, for example—and we'll know their participation has had some long-term benefits for both mother and child."

## *Best Advice*

- Allentown staff offer the following suggestions for maintaining productive relationships with teenage clients: Stay flexible, but work from a structure. Young people don't like rules, but they come to respect them. Invest time in creating trusting relationships, but follow through with consequences if behavior is an issue. One staff member offers: "You need to pick your fights. You pull and tug and then, sometimes, you need to back off."
- Cathy Liesman of Detroit advises others to prioritize major outcomes and avoid taking on too much. "This will help you send clear messages to two important groups of stakeholders: clients and funders," she explains. "Prioritizing will help anticipate the resources you need—such as a low staff-to-family ratio—and support accountability so you can be sure you finish what you start."
- Jean Sabharwal suggests involving as many stakeholders as possible in the planning process to increase ownership and responsibility for success. "We have involved everyone from bankers and IBM to our local Mary Kay representatives," she says happily. "Everyone has something to bring to this project."

## *Long-Term Challenges*

Project leaders in Allentown, Detroit, and Lexington identify the extent of young mothers' needs in relation to the demands of timely change and the scarcity of resources as the major challenge to successfully supporting change. "It's a struggle helping families who have been doing things this way for years," Liesman says. "People are being 'punished' for behaviors that are not new ones." Allentown staff agree: "With the change in welfare, students' involvement with us is very short-term—only six months. This decreases the chance of sustainable employment." Sabharwal of Lexington adds, "Some participants are at a third- or fourth-grade reading level when they enter the program. That's a long way from employable."

# *Safe and Sound:*
# Lessons Learned from Kellogg Foundation Programming

Grantees are uniformly vocal in support of the worth and necessity of focusing on adolescent health. However all acknowledge that the lessons to date mark a point of departure and a broad direction for communities, rather than a detailed map. The range of recommendations they offer reflect the complexity of the subject, the nuances of adolescent years, and the variety of circumstances young people face. If there is a single route for safe passage through adolescence, they have not yet discovered it. But grantees tell us there are ways to recognize dependable paths—and ways of knowing when to embark upon them.

## *Communities must make youth development and adolescent health a top priority.*

Advocates of young children can generate some heated public sentiment around child health issues. Recent passage of legislation to expand coverage for children of low-income families is a case in point. But adolescents have fewer advocates rallying support for investing in their development and health.

Our societal reticence to address adolescent health issues may be related to the behaviors particular to this passage. Americans harbor a general discomfort with adolescent sexuality, experimentation with risky behaviors, and age-appropriate challenges to authority. Yet adolescents have an uncanny way of exposing society's past shortcomings and suggesting future stumbling blocks.

Kellogg Foundation grantees consistently come face-to-face with the depth of our young people's unmet health needs. This is, in part, because we lack a mechanism for tracking adolescent health, they suggest. The well-child exams of the early years have no corollary when a child gets past the age of 11 or 12. Young athletes may be required to have cursory sports physicals. Campers may need a record of immunizations before they can get off the bus. But for most young people, health care is episodic, infrequent, and prompted only by severe illness or emergency.

Adolescents need more comprehensive care, grantees insist. They need innovative approaches to identifying, addressing, and tracking health issues—and communities, grantees believe, are the best places to begin this process. Communities are in the best position to appreciate the many consequences of poor health and reap the benefits of well-being. Communities must gather allies from health and human services, education, government, and business to respond to the needs of adolescents with the same level of urgency applied to reducing low birth weight or immunizing toddlers.

Tackling health issues maybe the best way to begin to address youth violence, teen pregnancy, and educational failure, grantees suggest. All are part of the same puzzle, they agree, but health issues offer a tangible starting point for community efforts. Focusing on adolescent health may offer a springboard for marshaling resources, attracting diverse partners, and placing adolescent issues at the top of a community's agenda.

*"We have found that with young people who are poor, the issue is often acute or chronic illness rather than well care or prevention. We find we need to get young people comfortable with the idea of visiting a doctor when they are not sick."*
*—Walter Niles, TRUST, Tampa-Hillsborough Urban League*

*"We define youth development very broadly to get to health issues."*
*—Annie Huff, BGACDC, Marvell, Arkansas*

## *Young people need comprehensive, coordinated services with multiple points of access.*

Grantees tell us there is no single way to connect with adolescents and no accepted "grocery list" of services they need. Within a few years' time the same young person may need widely different services, they claim. The developmental pace of each young person's adolescence combined with the unique individual, family, and community circumstances make it impossible to select one set of services or one way to access them.

Young people need access to basic services to maintain health—especially primary care and prevention services and dental care. Adolescent primary care must encompass health education, reproductive health, and mental health, too. But youth may also need services to enable participation—transportation, day care for preschool children, and family support resources.

Projects with the greatest success have designed very open systems with multiple points of access—through schools, churches, businesses, agencies, and providers. Rather than narrowing the channels to access services, they offer many ways, many options. But grantees advocate linking all channels to a mechanism to coordinate care and streamline service entrees.

For some programs, this has led to one-stop methods of service delivery. Given the geographic and cultural conditions of some communities, "under one roof" coordination may be the best way. For others, a very loose net of services with good communication is a better approach. The important element is the scope of the services and the level of coordination to benefit the young person, they say.

*"Our community services network links our program to all local services—churches, shelters, mentorship programs, as well as health and human service agencies. We are connected through the Internet and talk by e-mail."*
*—Mary Lou Eddinger, Case Manager, Expectant and Parenting Youth Program, Allentown, Pennsylvania*

*"We've had success with anything we can put under our roof because of the convenience to our clients."*
*—Jean Sabharwal, The Family Care Center, Lexington, Kentucky*

## *Communities need to address employment and economic development issues to improve adolescent health.*

Adolescent health and development issues are framed by the level of opportunity in the larger culture. Young people who live in communities where the adults around them cannot earn a living wage have no reason to suppose their own prospects will be very different.

When parents work, children and young people are free to learn and grow. When parents cannot support their families, young people and children share the burden. The poor, young people of color, and youth from isolated communities may be particularly hard hit by limited economic opportunities in the larger environment. Often they are the least prepared for employment by education or expectations at home. Their prospects, grantees say, may be the most precarious.

Those interested in improving the health of young people need to connect adolescent development with local education and economic initiatives, grantees attest. Finding ways to expand local economic horizons, create opportunities, and attract businesses are challenges common to many communities. But they may be as pivotal to fostering adolescent hopes as community development.

As part of the focus on employment and economic opportunity, grantees urge decisionmakers to look beyond entry-level employment for young workers. Adolescents need to see the work they do today leading to a better life tomorrow. Minimum-wage jobs, though a good starting point for entry-level workers, need to be part of a community career ladder. Young people—and their parents—need mechanisms to develop the skills employers seek and the opportunity to put them to good use.

*"We need to link education to employment. Education is part of a ladder that connects values and services to overall community development. The drug dealer says, 'What you make in a year, I can make in a day.' But that's not community development."*
*—Cheryl Boykins, Center for Black Women's Wellness, Atlanta, Georgia*

*"Health services are the greatest window of opportunity for looking beyond a specific program to determine need for community collaboration around issues."*
*—Walter Niles, TRUST, Tampa-Hillsborough Urban League*

## *Youth development is a more prudent investment than punishment.*

Our jails and juvenile homes may be increasingly filled with young offenders, but Kellogg grantees continue to call for investment in health care and education, not prisons. Developing programs that meet the complex needs of young people and their families may seem too costly an enterprise. However it is far less expensive, grantees emphasize, than the cost of incarcerating a fraction of the youngsters we are jailing each day. Certainly, coordinating substance abuse programs, educational remediation, and job training will demand time, money, and creativity. But the outlay today will be significantly less than the outlay to attempt the same thing in a decade or two—especially if the cost of even a few years of prison is added to the tally.

Our investments communicate a great deal about our expectations for the future. When we buy our children sports equipment and drive them to music lessons, we are telling them that we value their capabilities. When we insist they do their homework and meet their academic obligations, we are telling them we have expectations for their futures. But when we pick up the tab on prison expansions without complaint, we are telling the growing number of children who live in other homes and neighborhoods that we expect far less of them—in fact, that we expect them to fail.

As much as we all desire to live in a secure society, more cells and bigger prisons will not keep us safe. We need to give young people a stake in the future—to convince them by our collective actions that we expect them to contribute, to grow, to prosper in the years ahead. Investment in education and health care is one tangible way of communicating a more hopeful set of expectations.

Communities need to recognize investment in youth development as investment in long-term security on a larger scale. Young people are the products of the conditions in place today. Changing those conditions for the better will keep all of our children safe and ensure a productive future for young people in vulnerable communities.

*"Young people are a product of the total investment in them. It's not just the money spent, but the commitment brought to it."*
*—Cheryl Boykins, Center for Black Women's Wellness, Atlanta, Georgia*

## *Role models, outreach, and culturally-competent models of care enhance the effectiveness of programs targeting adolescents.*

Most successful adults can name the people who helped them along, the teachers or health providers who touched their lives, the idols who fired their imaginations and spurred them to persevere in the face of defeat or disappointment. Youth in vulnerable situations are no different. They can be touched by people, by stories, by information—and their lives can be changed for the better.

But poor youth, young people of color, youngsters living in isolated conditions—these adolescents may take more time and care to be reached. The circumstances of their young lives—early exposure to violence, neglect, sexual abuse, homelessness, school failure—may make them understandably wary of

authority figures. Even youngsters who reach adolescence unscarred by these harmful forces may be wary of adults, institutions, and systems.

To bridge the gap between young people and programs and services designed to help them, grantees relate their successes with various strategies. Some report that active outreach by community people brings teenagers to their doors. Other programs lean heavily on staff who represent positive role models to youngsters—people who look like them or come from the same culture, but who are a bit older, more experienced, seasoned in the ways of the world. Outreach workers, mentors, and other role models, many grantees tell us, are key to connecting with adolescents and providing support and guidance.

Others grantees assert that health and human service providers of any age, gender, or background can reach young people if they work from the young person's culture and frame their approaches accordingly. Culturally-competent models of care, they explain, imply that providers, educators, and others understand the conditions that have particular bearing on their lives. All providers need an awareness of—and training in—the issues that affect the people and communities in their care.

*"Culturally-competent models of care are important. We had limited access to care in our community and services were not provided by people sensitive to the health issues of African-American youth. We work with health professionals to educate them to our community's health issues and needs, and we have worked with the state-level Department of Health on this issue."*
*—Annie Huff, BGACDC, Marvell, Arkansas*

*"Peer mentors are the best resource we have."*
*—Walter Niles, TRUST, Tampa-Hillsborough Urban League*

*"I believe we need a way to provide our young men with a place where they can re-learn how to be young, to be tender, to be sensitive to all life. In my mind, this is a place where young men can be alone with sober, wise, strong Native male role models."*
*—Gina Kalloch, Tanana Chiefs Conference, Fairbanks, Alaska*

*Our Clubs: Pulaski County, Arkansas*

## *Community Combats Gang Appeal*

By 1991, an increase in violence and delinquent behavior among young people in Pulaski County was bringing more kids into the juvenile court system. Gangs were gaining turf in the greater Little Rock area and community residents felt "under siege." But despite the growing frustration of law enforcement officials and others, the Honorable F.G. "Buddy" Villines III knew there had to be a better way to stem the tide than by placing more and more young people in jail. With the help of then-Governor Bill Clinton, Villines assembled representatives from schools, human services, businesses, and neighborhoods. Together they began to craft a comprehensive strategy to combat gangs and provide incentives for positive behavior.

The Pulaski County Prevention Institute was an outgrowth of that early effort. And the nine Our Club sites in Little Rock neighborhoods today are a direct result of that collaborative beginning. Our Club sites have become hubs of after-school and weekend activities for young people and their families. They host a range of educational, developmental, social, and recreational programs all focused on bringing out the best in area teenagers.

Through the Our Club system, young people are recognized and rewarded for community service, school attendance, improvement in grades, and other achievements. The points they earn for positive activities can be redeemed at the Our

Club Mall—an entrepreneurial program operated by area youth. Adolescents handle the purchasing, marketing, and sales in their mall. Points net clothing, sports equipment, radios, and other goods purchased through partnerships with the Levi Strauss Foundation, Target Stores, Wal-Mart, and other area businesses and philanthropies.

Recognizing that it takes more than incentives to help young people develop safely, Our Clubs have added services that bring nurse practitioners, dentists, and physicians on-site to address health issues, provide routine sports physicals, and handle adolescent preventive health care. Psychological services and substance abuse treatment are part of the same package. The Our Clubs approach underscores the positive changes that can be made when parents, agencies, schools, businesses, health providers, and law enforcement officials work together on behalf of young people.

## *Providers targeting youth must work with and through adults in the community to foster health and hope in adolescents.*

Although young people often look grown and try to act grown, they still have a great deal of growing to do. As much as some in our society might prefer to deal exclusively—harshly or otherwise—with adolescents, grantees remind us that every young person has some connection with adults—in his home, neighborhood, church, or school. Parents, step-parents, aunts, uncles, grandparents, godparents, neighbors, pastors, teachers—all have a place in the development of a community's young people and a stake in ensuring safe passages.

Grantees urge providers and others working with young people to seek the active involvement of parents and other adults to address adolescent health issues. Programs never treat a single person, grantees tell us. Each person is part of a family, neighborhood, or culture that has bearing on the young person's development.

*"We need to help parents get back into their places. To impact generations, you need to work with the person responsible for the child. If a child is in crisis, generally his siblings and parents are, too. . . . Self-concept and identity are related to family. Families are what young people mimic. They practice what they see."*
*—Cheryl Boykins, Center for Black Women's Wellness, Atlanta, Georgia*

*"You can't talk about nutrition without talking to the person who prepares food. We had an 11-year-old boy who was overweight, had high blood pressure, and cholesterol over 300. But he was one of nine siblings and his mom was expecting another baby. We can't talk about resources for young people without taking into account the entire family."*
*—Walter Niles, TRUST, Tampa-Hillsborough Urban League*

## *School-based health care services are an effective outreach tool with young people.*

Although many people associate school-based clinics exclusively with sex education and birth control issues, grantees know their capabilities extend beyond these highly politicized issues. School-based health care can effectively bring services to the people they aim to serve. And what they learn about health issues and gaps in service can inform health decision making and allocation of resources at the community and state levels.

*"Our school-based clinic is on the borders of Texas, New Mexico, and Mexico, and the majority of our services are physicals. We are linked to primary care clinics and provide referrals depending on the need. We work very closely with public health on a number of levels.... At the elementary level, we work closely with the family. But school is where many young people spend much of their time. It's age-appropriate for high-school-aged teens to want to speak for themselves."*
*—Suzan Gonzalez, Adolescent Family Life Program, Sunland Park, New Mexico*

*"School-based clinics are another important access point. They deal uniquely with the community and are based on community health care resources."*
*—Cheryl Boykins, Center for Black Women's Wellness, Atlanta, Georgia*

# *Getting Our Bearings:* Implications for Providers, Programming, and Policy

In the presence of infants and small children, we freely acknowledge the adult role in nurturing and protecting. They have so much growing to do, we readily admit. They need us to help them. Eyeball-to-eyeball with a teenager, however, it is less easy to see that nurturing and protecting are needed. But adolescents have a lot of growing to do, too.

Young people have a long way to go before they become fully formed men and women—and they need time and space to continue developing physically, cognitively, and emotionally. As adults we must embrace the responsibility of protecting and nurturing all of our nation's young men and women—and begin to act accordingly. In the systems and policies we create, the programs we endorse and support, and the resources we commit, we must lay claim to our young people and make our resolve felt.

Certainly in theory, policymaking in a democracy integrates the will of the people. But too often, it seems, policies and regulations are determined far from the voices of those who bear the burden of harsh or unrealistic changes. So if we seek to chart a more promising course for our young people, the thoughts, hopes, and dreams of today's powerless must be heeded. If we choose to ignore their calls, we set the stage for a legacy of illness and deprivation that all of our children will ultimately suffer—and support.

But if we choose to invest in the health and hopes of our young people, the time, energy, and money we expend now will produce significant savings in the future. Although the extent of adolescent health needs may seem overwhelming, the relative price tag may never be lower. Substance abuse, teen pregnancy, violence, HIV/AIDS, smoking—the cost of dealing with these health hazards will only increase with time.

The experiences of Kellogg Foundation grantees—the strides they have made and the long-term challenges they anticipate—have implications for decision-makers in many of our nation's institutions. Leaders in community-based projects call for policymakers, funders, and providers to identify ways to support community-based efforts and participate in the process of protecting youth.

## How Policymakers Can Improve Adolescent Health

Create policy options that acknowledge the complexities of changing behaviors, habits, and expectations.

Look for ways to streamline regulations and simplify bureaucracies to allow community-based and public agencies to meet health needs and receive payment.

Seek to fund research that will expand societal understanding of the many determinants of adolescent health—including physical, social, emotional, cognitive, economic, and cultural factors—and of the service models that can address them.

Examine health professions education and health services funding to expand the availability of midlevel and outreach providers to address community health needs.

Explore policy options that foster coordination and collaboration within communities to address complex problems.

Support community efforts to address adolescent health issues now as a way of reducing costs later.

Link community development grants to health service and other delivery programs.

## How Funding Organizations Can Improve Adolescent Health

Support innovative approaches and long-term data collection and analysis to evaluate the actual costs and long-term benefits of investing in youth.

Communicate accurate information about the conditions that hamper youth development and all the causes of ill health—including those related to current policies and systems.

Support faith-based and other nontraditional programs that improve adolescent health and community safety.

Support projects that promote coordination of resources within communities.

Respect the fact that change—in communities, in systems, in people—takes time.

## How Providers Can Improve Adolescent Health

Foster the use of multidisciplinary teams to address complex adolescent health issues.

Seek to provide data on adolescent health status and youth conditions to decision-makers in business, government, education, and higher education.

Identify service barriers related to Medicaid and managed care regulations and advocate within local, state, and federal systems to improve service to vulnerable clients.

Develop protocols for adolescent health care that include linking with enabling services and local resources.

Recognize the value of culturally-competent models of care and promote training and continuing education of health professionals consistent with its approach.

Work with and through community resources—community-based organizations, midlevel providers, and outreach workers—to streamline access for young people and their families and provide needed care.

# Resources

**Adolescent Family Life Program**
715 E. Idaho
Suite 3E
Las Cruces, NM 88005
505/523-2042
FAX: 505/526-9650

**Advocates for Youth**
1025 Vermont Avenue NW, Suite 200
Washington, D.C. 20005
202/347-5700
FAX: 202/347-2263
http://eos.atmos.washington.edu/~robert/Advocates

**Alcorn State University School of Nursing**
Family-Centered Adolescent Health Promotion
15 Campus Drive
Natchez, MS 39120
601/442-3901

**Auburn University Montgomery School of Nursing**
P.O. Box 244012
Montgomery, AL 36124-4023
334/244-3666
FAX: 334/244-3243

**Baltimore Medical System, Inc.**
SET for Success
3501 Sinclair Lane
Baltimore, MD 21213
410/732-8800
FAX: 410/276-3694

**Boston Unites to Raise Its Children**
Center for Community Health, Education, Research and Service (CCHERS)
Northeastern University
360 Huntington Avenue, Room 398CP
Boston, MA 02115
617/373-4591
FAX: 617/373-8797

**Boys, Girls, Adults Community Development Center (BGACDC)**
P.O. Box 1356, Highway 49
Marvell, AR 72366
870/829-3274
FAX: 870/829-2282

**Center for Black Women's Wellness, Inc.**
Room 309, 477 Windsor SW
Atlanta, GA 30312
404/688-9202
FAX: 404/880-9435
Email: cbwwatl@aol.com

**Center for Policy Alternatives**
1875 Connecticut Avenue NW, Suite 710
Washington, D.C. 20009
202/387-6030
FAX: 202/986-2539
Email: info@cfpa.org
www.cfpa.org

**Challengers Boys and Girls Clubs of Metro LA**
P.O. Box 37189
5029 S. Vermont Avenue
Los Angeles, CA 90037-0189
213/971-6161
FAX: 213/751-7071

**Children's Defense Fund**
25 E Street NW
Washington, D.C. 20001
202/628-8787
FAX: 202/662-3510
Email: cdfinfo@childrensdefense.org
www.childrensdefense.org

**The Corner Health Center**
47 North Huron
Ypsilanti, MI 48197
313/484-3600
FAX: 313/484-3100

**East Carolina University**
Department of Family Medicine
Adolescent Health Project
Greenville, NC 27858
919/816-5459
FAX: 919/816-4614

**Expectant and Parenting Youth Program**
Private Industry Council of Lehigh Valley, Inc.
Workforce Development Center
1601 Union Blvd.
P.O. Box 20490
Lehigh Valley, PA 18002-0490
610/437-5627
FAX: 610/437-1715

**Families USA Foundation**
1334 G Street NW
Washington, D.C. 20005
202/628-3030
FAX: 202/347-2417
Email: info@familiesusa.org
www.familiesusa.org

**Family Care Center**
1135 Red Mile Place
Lexington, KY 40504
606/288-4040
FAX: 606/288-4061

**Family Resource Center**
The Guidance Clinic
2615 Stadium Drive
Kalamazoo, MI 49008
616/382-7080
FAX: 616/382-7078

**Forum on Adolescence**
Board of Children, Youth, and Families
National Research Council
2101 Constitution Avenue NW
Room HA 156
Washington, D.C. 20418
202/334-1937
FAX: 202/334-1937

**Girls Incorporated National Resource Center**
441 West Michigan Street
Indianapolis, IN 46202
317/634-7546
FAX: 317/634-3024
Email: HN3580@handsnet.org
www.girlsinc.org

**Haitian Community Health Information and Referral Center**
1783 Bedford Avenue
Brooklyn, NY 11225
718/826-2100
FAX: 718/826-6140

**Johns Hopkins University**
Department of Sociology
3400 N. Charles Street
Baltimore, MD 21218
410/516-7632
FAX: 410/516-7590
Email: jhuips@jhunix.hcf.jhu.edu
www.jhu.edu/~ips/

**Joint Center for Political and Economic Studies**
1090 Vermont Avenue NW
Suite 1100
Washington, D.C. 20005-4961
202/789-3500
FAX: 202/789-6390
www.jointctr.org

**JONAH (Just Organized Neighborhoods Area Headquarters, Inc.)**
525 East Main Street, Suite 103A
Jackson, TN 38301
901/427-1630
FAX: 901/427-2689

**Latin American Youth Center**
3045 15th Street NW
Washington, D.C. 20009
202/483-1140
FAX: 202/462-5696

**Lummi Cedar Project**
Group Health Cooperative/Puget Sound
1790 Bayon Road
Bellingham, WA 98226
360/738-7867
FAX: 360/738-7894

**Manpower Demonstration Research Corporation**
16 East 34th Street, 19th Floor
New York, NY 10016-4326
212/532-3200
FAX: 212/684-0832
Email: information@mdrc.org
www.mdrc.org

**Memphis City Schools**
Adolescent Parenting Program
1266 Poplar Avenue
Memphis, TN 38104
901/722-4412
FAX: 901/722-4401
www.memphis-schools.k12.tn.us

**National Asian Women's Health Organization**
250 Montgomery Street, Suite 410
San Francisco, CA 94104
415/989-9747
FAX: 415/989-9758
Email: nawho@aol.com
www.nawho.org

**National Assembly on School Based Health Care**
1522 K Street NW, Suite 600
Washington, D.C. 20005
1-888-286-8727 or 202/289-5400
FAX: 202/289-0776

**National Association of Child Advocates**
1522 K Street NW, Suite 600
Washington, D.C. 20005
202/289-0777
FAX: 202/289-0776
www.childadvocacy.org

**National Center for Juvenile Justice**
710 Fifth Avenue
Pittsburgh, PA 15219-3000
412/227-6950
FAX: 412/227-6955
www.ncjj.org

**National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)**
1501 16th Street NW
Washington, D.C. 20004
202/797-4324
FAX: 202/7974353
Email: info@cossmho.org
www.cossmho.org

**National Coalition on Health Care**
555 13th Street NW
Washington, D.C. 20004
202/637-6830
FAX: 202/637-6861
Email: info@nchc.org
www.nchc.org OR www.americashealth.org

**The Nelson A. Rockefeller Institute of Government**
411 State Street
Albany, NY 12203-1003
518/443-5844
FAX: 518/443-5823
Email: fedgroup@rockinst.org
www.rockinst.org

**Office of Minority Health Resource Center**
P.O. Box 37337
Washington, D.C. 20013-7337
800/444-6472
FAX: 301/589-0884

**Pulaski County Council for Children and Youth Services/Our Club**
201 S. Broadway, Suite 370
Little Rock, AR 72201
501/340-8250
FAX: 501/340-6282

**RAND Corporation**
P.O. Box 2138
1700 Main Street
Santa Monica, CA 90407-2138
310/393-0411
FAX: 310/393-4818
Email: correspondence@rand.org
www.rand.org

**Rural Health Outreach Program**
Medical College of Georgia School of Nursing
997 St. Sebastian Way, EG-3001
Augusta, GA 30912
706/721-6175 or 706/721-6289
FAX: 706/721-7077
www.mcg.edu/son/Resc.htm#RHOP

**Save the Children Federation**
54 Wilton Road
Westport, CT 06880
203/221-4000
FAX: 203/226-6709
www.savethechildren.org

**School-Based Health Initiative**
Henry Ford Health System
One Ford Place
Detroit, MI 48202
313/874-5426
FAX: 313/874-4035

**Targeting Healthy Communities**
California State University, Dominguez Hills
Division of Nursing
1000 East Victoria Street
Carson, CA 90747
310/243-2050
FAX: 310/516-3542

**Teen Parent/New Chance Program**
Development Centers, Inc.
24424 West McNichols Road
Detroit, MI 48219
313/531-2500
FAX: 313/531-1943

**Tribal Health Authority**
White Mountain Apache Tribe
Mothers Too Project
P.O. Box 1210
Whiteriver, AZ 85941
520/338-4955
FAX: 520/338-1615

**TRUST (Teaching Respect, Understanding, Self-Esteem, and Togetherness) for the Development of African-American Youth**
Tampa-Hillsborough Urban League, Inc.
1405 Tampa Park Plaza
Tampa, FL 33605
813/229-8117
FAX: 813/221-3947

**Tutwiler Clinic, Inc.**
P.O. Box 462
205 Alma Street
Tutwiler, MS 38963
601/345-8334
FAX: 601/345-8334

**The Urban Institute**
2100 M Street NW
Washington, D.C. 20037
202/974-2231
FAX: 202/293-1918
Email: paffairs@ui.urban.org
www.urban.org

**Valley Wide Health Services, Inc.**
Adolescent Health Program
204 Carson Avenue
Alamosa, CO 81101
719/589-5161
FAX: 719/589-5722

**Vanderbilt University**
School of Nursing
Godchaux Hall
Nashville, TN 37240
615/322-4400
FAX: 615/343-3998

**West Alabama Health Services, Inc.**
P.O. Box 599
Eutaw, AL 35462
205/372-3281
FAX: 205/372-9513
Email: wahs@aol.com

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Executive Summary

# Safe Passages Through Adolescence

## Communities Protecting the Health and Hopes of Youth

Lessons Learned from W.K. Kellogg Foundation Programming

W.K. KELLOGG FOUNDATION

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W.K. KELLOGG FOUNDATION
To help people help themselves

The W.K. Kellogg Foundation was established in 1930 "to help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations." Its programming activities center around the common visions of a world in which each person has a sense of worth; accepts responsibility for self, family, community, and societal well-being; and has the capacity to be productive, and to help create nurturing families, responsive institutions, and healthy communities.

To achieve the greatest impact, the Foundation targets its grants toward specific focal points or areas. These include: health; food systems and rural development; youth and education, and higher education; and philanthropy and volunteerism. When woven throughout these areas, funding also is provided for leadership; information systems/technology; efforts to capitalize on diversity; and family, neighborhood, and community development programming. Grants are concentrated in the United States, Latin America and the Caribbean, and southern Africa.

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Battle Creek, MI 49017-4058

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***May 1998***

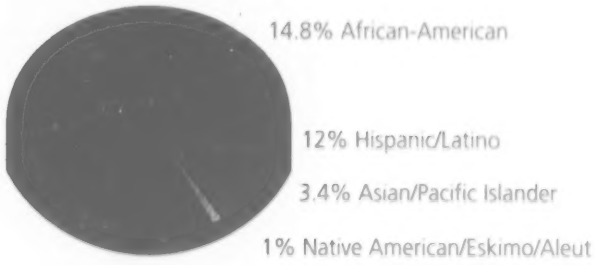
# *The Journey to Adulthood:* America's Youth

Certainly, the transition from childhood to adulthood has never been easy for young people or adults. Hormonal changes, cognitive development, and the need to assert independence have always translated into defiant behavior, peer clannishness, and distance from family members in the adult's experience. How, we might ask, are the conditions of adolescents today more dire than those of past generations?

A number of factors support a genuine cause for concern. For one thing, the numbers of young people are growing and, as such, they represent a greater proportion of the population. The teenage population is expected to rise by as much as 20 percent in the next 10 years and the percentage of poor, minority teens to increase even more. In 1992, 34 million young people (ages 10-19) comprised 14 percent of the population. By 2020, it is estimated that number will have grown to 43 million. (U.S. Bureau of the Census P25-1111, 1994; U.S. Bureau of the Census PPL-8, 1993)

The number of young people of color grew by almost 28 percent between 1980 and 1991 (U.S. Bureau of the Census PPL-8, 1993). The one-third these young people represent today is expected to balloon into almost half the adolescent population by 2050 (Carnegie Council on Adolescent Development, 1996).

Percentages of Young People of Color in the U.S.*




*Youth ages 10-19 in 1992
Source: U.S. Bureau of the Census PPL-8, 1993

As the number of young people increases, the proportion of our youth living in poverty swells as well. The children of families of color are far more likely to live in poverty than other children in the United States. One of every three Hispanic children lives in poverty. Among African-Americans, that number increases to one of every two. And an estimated nine of ten Native American children live in impoverished households. (Elders, 1994)

With poverty comes a familiar array of health and societal challenges. Poverty is correlated with an individual's access to health care, education, employment, housing, exposure to violence, and a great many other determinants of health. Again and again as a society we come face to face with evidence of the difficulty of extending opportunities to all. The poor, minorities, and those isolated by social or geographic barriers suffer the shortfalls of our society disproportionately across every measurable variable.

*"The main determinant of children's health is the physical and social environment in which they grow."*

— *L.V. Klerman*
*Department of Maternal and Child Health, University of Alabama at Birmingham*

## *Adolescent Health Status: The Consequences of Poverty and Social Isolation*

Children living in poverty are often in poor health compared with children from more affluent families. Good health depends upon preventive services and access to primary health care. But prevention and access to services are difficult without adequate resources. The more financial resources a family has, the more likely the children will be healthy (Coiros, Zill, and Bloom, 1994).

Approximately 16 percent of youth ages 13-17 have no health insurance. As with other uninsured children, a disproportionate share of uninsured adolescents are poor, members of a minority group, or both. Twenty-two percent of uninsured children are Hispanic. African-Americans make up 19 percent, and other minorities 5 percent. (Families USA Foundation, 1997)

Among the social trends that comprise the adolescent health landscape, changes in the family structure, the prevalence of teen pregnancy, the effects of violence, and the consequences of risky behavior—substance abuse, smoking and other tobacco use, and early sexual activity—are of particular concern.

### Symptoms of Adolescent Ill Health

25% of young people are victims of assault

12.5% suffer injuries related to being victimized

10.5% are sexually assaulted or abused

Marijuana use has doubled among eighth graders since 1991

Source: a national survey of adolescents age 10 to 16 (Joffe and Wilson, 1995)

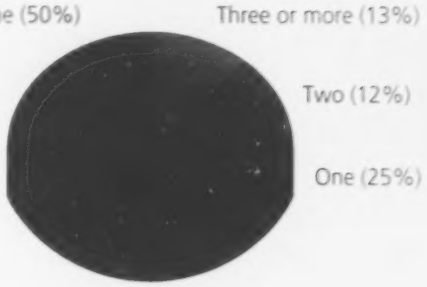
*"As adults in a community, we will give the children around us our time, our attention, our money, and our resources—one way or the other. It is through public policy that we decide whether it's going to be early on, in a loving and preventive way, or whether it's going to be at 4 o'clock in the morning when they are throwing bottles at cars to hear the alarms go off."*

*—D. Prothrow-Stith*
*Assistant Dean, Office of Government & Community Programs, Harvard School of Public Health, Cambridge, Massachusetts*

Risk Factors for America's Youth

Living in poverty
Welfare dependence in the family
Both parents absent
Single-parent families
Unwed mothers
Parent who has not graduated from high school

Percent of Risk Factors Among 16- and 17-Year-Olds




*Source: U.S. Bureau of the Census, 1997*

# *No Clear Course:* Public Policy, Health Care, and Adolescent Well-Being

Social forces focused on fostering the development of healthy, productive young adults appear to be diminishing, along with resources and the active and vocal commitment of adult citizens to support the development of the next generation. In 1995, the federal government spent a total of $167.2 billion on corporate business "welfare," or $1,388 per individual taxpayer. By contrast, the government spent a fraction of that figure—$50 billion—on Aid to Families with Dependent Children (AFDC), food stamps, and other forms of social welfare programs, or $415 per individual taxpayer (Pianin, 1995). Even the poor have a share in paying for the maintenance of a healthy economy. Yet their return on the "investment" is often disappointing.



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## Medicaid

In 1994, almost 2.7 million low-income children who had no health insurance were eligible for Medicaid, but not enrolled (Sumner, Perritt, and Mann, 1997). Prior to enactment of the State Children's Health Insurance Program in 1997, few states had acted upon the Medicaid option of providing coverage to qualified young people up to age 19. And only a few states modified allowable insurance packages to require preventive care coverage for adolescents or maternity coverage for nonspouse dependents. (Klein, Slap, Elster, and Cohn, 1993)

## School-Based Health Services

The challenge for school-based health centers is to become part of the evolving managed care system and enhance access while producing outcomes that control cost (Hacker, 1997). Still, school-based centers may remain the best option for adolescents who live in rural areas where distance to facilities is great and few services of any kind are available, or in the inner city where similar difficulties are encountered with transportation and poor access to quality care.

*"The problem with the use of the term 'cost-effective' is that the definition is too narrow. Policymakers do not typically understand cost-effectiveness in terms of what is needed to improve the health of adolescents."*

*— A. English*
*Program Director, Adolescent Health Care Project, National Center for Youth Law, Chapel Hill, North Carolina*

## Managed Care and Market Forces

Economic forces are currently driving health care systems and the services they provide. Market share, capitation, and provider concerns are all at the forefront of many health system decisions. Some traditional safety net providers—community health centers, public hospitals, and academic health centers—are losing their Medicaid population to other private plans. As their paying clients dwindle, some face an environment fraught with financial peril as they look for ways to afford the uncompensated care they have historically provided. The free care they have always provided to the poor and their children may be at risk in this shifting scenario.

## Welfare Reform: The Personal Responsibility and Work Opportunity Act

The number of children who are poor and extremely poor may increase due to welfare reform legislation. The Personal Responsibility and Work Opportunity Act of 1996 terminates income support for many and significantly curtails income support for families now receiving cash assistance, including families with children with disabilities. Given the strong relationship between income and child health, as well as the legislation's health care restrictions, the Act presents a serious threat to the health and well-being of children (Children's Defense Fund, 1996).

## The State Children's Health Insurance Program (S-CHIP)

The Balanced Budget Act of 1997 created an expansion of children's health insurance enacted as Title XXI of the Social Security Act. Forty billion dollars in federal matching funds will be available to states over the next decade to expand coverage to uninsured children. Issues not yet resolved include whether children will receive coverage for vision and hearing services; care for children with special needs; the degree to which low-income families are protected against cost-sharing that would make care unaffordable; and whether states are required to use all of the funding for coverage of uninsured children.

## Research to Support Decisions

In 1995, the federal government invested about $2 billion—less than 3 percent of the total federal research enterprise—in research designed to help clarify factors that affect the growth and development of 70 percent of the U.S. population—the more than 80 million children and adolescents. Private foundations invested another $25 million and states and local government also funded some studies. (National Science and Technology Council, 1997)

Considering how little we know and how much we need to learn, the amount committed to gathering knowledge suggests a serious shortfall in investment. And in an era when public expenditures are increasingly based upon bottom-line thinking, credible data to support decisionmaking becomes even more crucial. Most experts would agree that we have baseline data about the depth and extent of adolescent health problems. What we need is more information about useful applications of what we know to move decisionmakers in communities, organizations, and institutions to productive action.

# *Promising Paths:*
## Kellogg Foundation Projects

Kellogg Foundation projects suggest promising community-based approaches to improving the health and fueling the hopes of young people. Some projects are found in urban centers, others in remote rural regions. Some provide traditional medical services, others focus on cultural traditions to reach young people. Each is unique, but they are characterized by some striking similarities as well. All identify adolescent health and well-being as a community priority; all respect the needs and capabilities of the total person within a cultural or community context; and all draw on resources in neighborhoods, within institutions, and across disciplines to invest in youth.

The projects profiled in the following pages have turned potential barriers into opportunities. Their actions for curbing teenage [illegible] and methods of improving health status, expanding long-term prospects, and supporting the development of young people are offered here as possible paths for other communities. The variety of their experiences is tangible proof that no one approach works for every group. Each passage, they seem to tell us, is a fresh journey. But the models grantees have developed offer markers for those traveling the same roads—and some options for communities seeking safe passages for their youth.

# TRUST

Teaching Respect, Understanding, Self-Esteem, and Together-ness for the Development of African-American Youth

East Tampa, Florida

## Project Description

Since its inception in 1989, the Trust the for Development of African-American Youth has targeted improving the health and well-being of young men in the Belmont Heights neighborhood through culturally-sensitive recruitment, physical examinations and screenings, and health education. The Trust, a project of the Tampa-Hillsborough Urban League, Inc., has built upon the provision of needed primary health services to connect with young people and their families, coordinate services with area schools and the health department, and link with resources in the community, among health professionals, and within academic institutions. More than 400 young people each year receive physical examinations and follow-up treatment through the Trust. Of these, between 250 and 300 participate in the Children of the Sun health education program each year.

## Program features:

- primary care health screenings, follow-up testing, and treatment for adolescents and their families
- services provided by students from the University of Southern Florida Colleges of Nursing and Medicine, Hillsborough County Public Health Department, and volunteer health professionals from the Bay Area Medical Association (BAMA) and Minority Nurses' Association of Hillsborough County
- [illegible] conditions prevalent among African-Americans
- Children of the Sun School – culturally-appropriate instruction on development issues for young people
- cultural-awareness training for health care professionals and agency staff
- adult support programs
- summer youth employment program

## Outcomes:

- helped inform policy regarding the need to help working people not eligible for Medicaid
- 1,500 youth physicals completed identifying conditions including high cholesterol (28 percent of young people examined), anemia (20+ percent), curvature of the spine (23 percent), and dental cavities (70+ percent)
- Curriculum for 14-week youth development course
- Development of health center to provide needed services
- [illegible] judges refer youthful offenders to the Trust
- parents "self-refer" young people to the program
- program expanded to include young women

# Lummi Cedar Project

## Bellingham, Washington

## Project Description

The Lummi Cedar Project draws on the rich tradition of the Northwest coastal tribes in its approach to youth development and health improvement. One of seven consortia in the Washington Community-Based Public Health Initiative, Lummi Cedar Project efforts are part of a larger commitment to improving public health education by linking the training of health professionals with the needs of underserved communities. The Lummi Cedar Project identifies four goals for improving community health—each founded on traditional values: (1) a commitment to strenuous physical exercise; (2) a healthy diet based on traditional rather than processed foods; (3) a drug-free community; and (4) limiting sexual activity to times when it is appropriate.

Lummi have always lived near the sea. For hundreds of years the canoe was not only vital to survival, but a symbol of the endurance, skill, and dignity of a people. Canoes allowed the Lummi to fish, gather food, trade, and travel. And through the sport of canoe pulling in years past, the Lummi people blended physical strength, teamwork, and determination to successfully compete with other nations. In canoe pulling today, the Lummi Cedar Project has identified a mechanism for promoting health, engaging youth, drawing on community strengths, and deepening cultural relevance to present-day challenges.

## Program features:

- conditioning and training to increase youth involvement in sport of canoe pulling
- participation in canoe pulling competition throughout the region and nationally
- community focus on traditional activities to support athletics, such as fundraising and dedication of a new 11-person canoe to add to the fleet
- water safety, CPR, and first aid instruction for community members, especially canoe pullers, skippers, and coaches
- ongoing education about diseases and other conditions that threaten community health and well-being including HIV/AIDS, substance and alcohol dependence, smoking, and consumption of processed foods

## Outcomes:

- 501(c)3 status to continue program
- increased participation in sport (up to 70 canoe pullers)
- commitment to healthy lifestyle for young people participating in sport
- HIV/AIDS peer training and workshops
- deepening of cultural traditions among community members of all ages
- ongoing health education activities including health fairs and annual conferences
- youth and adult participation in swimming lessons, CPR, first aid training and other related activities

# *Adolescent Family Life Program*
## Sunland Park, New Mexico

715 E. Idaho
Suite 3E
Las Cruces, NM 88005
505/523-2042
FAX: 505/526-9650

### *Project Description*

The Adolescent Family Life Program in Sunland Park, New Mexico, is an outgrowth of the successful La Clinica de Familia program in urban Las Cruces. A comprehensive health and education program for pregnant and parenting teens, the Adolescent Family Life Program is focused on keeping young women in school by addressing their medical, physical, and emotional needs during and after pregnancy. Working through the public schools and with the assistance of community promotoras, the family-centered, community-based program has been able to reach a significant number of pregnant teens in its first few years of operations.

### *Program features:*

- school-based and community counseling and case management
- job placement, resume writing, and interview skill development
- education of health professions and social work students
- parenting and prenatal care
- reproductive health education including parenting, prenatal, and newborn care
- referrals for GED classes

### *Outcomes:*

- provision of wraparound services for pregnant and parenting teens
- collaboration with agencies serving teens
- coordination of limited resources
- 183 young people served in Sunland Park facility in 1996 (142 young women; 41 male partners)

# *Center for Black Women's Wellness*
## Atlanta, Georgia

Room 309, 477 Windsor SW
Atlanta, GA 30312
404/688-9202
FAX: 404/880-9435
Email: cbwwatl@aol.com

### *Project Description*

The Center for Black Women's Wellness is a community-based, self-help center dedicated to improving the mental, physical, and spiritual growth of women and their families, and the economic growth of communities. Since 1988, the Center has expanded upon a broad definition of health and collaboration with other institutions to offer a growing array of services including traditional health screening, assessment, and referral; health and self-care education focused on prevention; basic education and GED preparation; vocational skills and computer training; self-help group development; and teen pregnancy prevention.

### *Program features:*

- Plain Talk, a teen pregnancy prevention and sex education discussion program
- health screening, assessment, and education
- referrals for GED and employment education
- micro-enterprise program
- summer youth leadership program

### *Outcomes:*

- increased community participation in focus groups, surveys, and other issue-focused activities
- increased use of center facilities for education, self-help groups, and health screening (more than 1,500 patron visits in 1996)
- collaboration with area health and human service agencies

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# *The Corner Health Center*
## Ypsilanti, Michigan

47 North Huron
Ypsilanti, MI 48197
734/484-3600
FAX: 734/484-3100

## *Program Description*

Since opening its doors in 1981, The Corner Health Center has filled a health care gap for young people in southeastern Michigan. From an annual budget of $11,500 its first year, "The Corner," as it is called by patrons and staff alike, has grown to an organization providing a wide range of health and human services with an annual budget of $1 million. In 17 years of operations, The Corner has changed in size and its growth has prompted more than one change of location. But the premise it was founded upon—providing needed health services to young people ages 12 to 21 and their children under a single roof—remains intact. The effectiveness of this approach has been documented by data showing improved health outcomes and a steady increase in the demand for services.

In the course of its work with young people, The Corner has explored numerous ways to connect with adolescents and involve them in decision making and education. This commitment to serving and engaging clients has led to development of The Corner Theatre Troupe and a successful peer health educator program. Both efforts are part of The Corner's focus on prevention.

## *Program features:*

- obstetric, pediatric, family planning and other medical services
- access to human services including the Women, Infants and Children (WIC), Maternal Support Services (MSS), and Infant Support Services (ISS) programs
- HIV counseling and testing
- health professions education
- peer educators trained to offer pregnancy prevention education and assist in lab work
- youth theater troupe performing skits that deliver prevention messages related to substance abuse, sexually-transmitted diseases, HIV/AIDS, and violence prevention

## *Outcomes:*

- decrease in teen birth rate (declined by 56 percent in Ypsilanti)
- no very-low-birthweight babies born to Corner patients
- Caesarean birth rate of only 12 percent
- average weight gain in pregnancy of 30 pounds
- 1,000 family planning and 150 maternity patients per year
- WIC services to 700 teen mothers and their children each month
- 100 adolescents and health professional trainees oriented
- development of extensive curriculum materials for medical residents and other health professions students working at The Corner

# *Boys, Girls, Adults Community Development Center, Inc.,* Marvell, Arkansas

P.O. Box 1356, Highway 49
Marvell, AR 72366
870/829-3274
FAX: 870/829-2282

## *Project Description*

The Boys, Girls, Adults Community Development Center (BGACDC) describes itself as an organization helping people build new lives, hopes, and dreams. Founded in a small Delta town in 1978 by parents coming together for their children, BGACDC represents a strong grassroots organization that nurtures families, draws on the strengths of adults and elders, and challenges and encourages young people. BGACDC's holistic approach to health and development includes extensive programming and economic development initiatives—such as the Center's restaurant, laundromat, and 39-unit multifamily housing development.

Programs include PREP (Pre-stepping for Success) for children ages 6 and 7; GAG (Girls are Girls) for young women at risk of school failure and teen pregnancy; and DAD (Dealing with Adolescent Development), a program targeting young African-American males. Additional services include day care, after-school care, and job training. To foster development of BGACDC initiatives, the Center partners with school districts, the health department, churches, local governments, health care providers, a four-county workforce alliance, arts organizations, and county extension services.

## *Program features:*

- preschool education and day care
- full range of parenting programs targeting different age groups
- summer day camp and Saturday activity program at youth center
- intergenerational program linking seniors at housing complex with youth

## *Outcomes:*

- Marvell Medical Center opened in 1996
- very high immunization rate (nearly 100 percent) among children entering kindergarten
- collaboration with four-county workforce alliance
- participation in welfare reform task forces at the state and local levels
- multiple commercial ventures (low-income housing complex, laundromat, day care center, restaurant)

# *Boston Unites to Raise Its Children*

## Boston, Massachusetts

Center for Community Health, Education, Research and Service (CCHERS)
Northeastern University
360 Huntington Avenue, Room 398CP
Boston, MA 02115
617/373-4591 FAX: 617/373-8797

## *Project Description*

Boston Unites to Raise its Children is rooted in approaches that join the resources of communities and institutions to solve complex problems. As early as 1990, a Kellogg-funded program called Healthy Transitions/Healthy Futures was targeting the well-being and education of adolescents at Boston High. The experience from providing on-site health services, wraparound family support, mentoring, and health careers curriculum was the basis for the Health Careers Academy. And CCHERS, the organization that operates the Health Careers Academy, was one of seven Kellogg Foundation Community Partnerships with Health Professions Education projects targeting the education of primary health care professionals in out-of-hospital settings. CCHERS brought extensive insight to the challenge of drawing academe, business, and health systems into a working partnership. The Health Careers Academy's advances in only three years of operations reflect the diligent efforts and insight of these groundbreaking projects. Today the Health Careers Academy has 160 students in ninth, tenth, and eleventh grades at two campuses in Boston. Working with and through the Boston Public Schools, Northeastern University, and a network of community health centers, the Academy is educating young people, touching their families, and changing the way health professions education institutions and health systems build the pipeline for the workforce of the future.

## *Program features:*

- expanded curriculum that integrates health and health careers content into academic disciplines
- practical experience in health care settings as part of curriculum
- health services on site for students
- health career exploration through community service and internships
- mentoring
- significant after-school academic support through tutoring, study groups, and workshops
- summer work program
- student and family support through student services coordinators and academic counselors
- active parental involvement in the student's educational plan

## *Outcomes:*

- viable model for linking university to public education
- improved student attendance
- higher test scores than public school peers
- increase in number of students electing to attend the Health Careers Academy
- student governance council involved in school's decision-making process
- advisory board that includes parents and diverse community interests
- greater participation and collaboration among business and higher education partners
- expanded programming for families, including Spanish-language GED classes
- welfare-to-work model
- Horace Mann Charter School status

# *New Chance,* Detroit, Michigan; Allentown, Pennsylvania; and Lexington, Kentucky

## *Program features:*

- day care
- medical screening and health services
- education for GED or vocational training
- reading instruction
- parenting skill development and support
- family planning education
- case management services

## *Outcomes:*

- identified the range and extent of challenges facing teenage mothers entering the workforce
- fostered successful partnerships in very different communities
- increased reading and employment levels of participants

## *Project Description*

New Chance, a national research and demonstration program, was designed to provide information about the behavior of young mothers receiving welfare, the problems they face, and their efforts to move toward self-sufficiency. New Chance programs offered an array of services, but were grounded in education. The 16 programs operating in 10 states provided academic and vocational skills to move young women into the workforce, and parenting and interpersonal skills to improve relationships and the quality of decisionmaking. The New Chance model also focused on improving the cognitive, social, and physical development of participants' children. New Chance was conducted between 1989 and 1992. Twelve of the 16 sites continue operations.

The sites in Allentown, Pennsylvania, Detroit, Michigan, and Lexington, Kentucky were funded in part by the Kellogg Foundation. The parent organizations of the three projects reflect the range of community champions interested in easing teenage mothers into the workforce.

The **Expectant and Parenting Youth Program** in Allentown is part of the Private Industry Council of Lehigh Valley—an employment and training organization.

Private Industry Council of Lehigh Valley, Inc.
Workforce Development Center
1601 Union Blvd.
P.O. Box 20490
Lehigh Valley, PA 18002-0490
610/437-5627
FAX: 610/434-4122

The **Teen Parent/New Chance Program** in Detroit is affiliated with Development Centers, Inc.—a private, nonprofit behavioral health care agency.

Development Centers, Inc.
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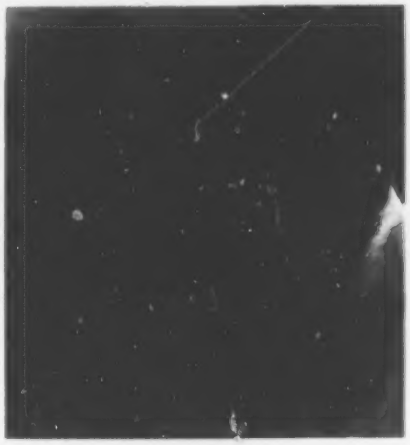
# *Safe and Sound:*
## Lessons Learned from Kellogg Foundation Programming



Grantees are uniformly vocal in support of the worth and necessity of focusing on adolescent health. However all acknowledge that the lessons to date mark a point of departure and a broad direction for communities, rather than a detailed map. The range of recommendations they offer reflect the complexity of the subject, the nuances of adolescent years, and the variety of circumstances young people face. If there is a single route for safe passage through adolescence, they have not yet discovered it. But grantees tell us there are ways to recognize dependable paths—and ways of knowing when to embark upon them.

### *Communities must make youth development and adolescent health a top priority.*

Communities are in the best position to appreciate the many consequences of poor health and reap the benefits of well-being. Communities must gather allies from health and human services, education, government, and business to respond to the needs of adolescents with the same level of urgency applied to reducing low birthweight or immunizing toddlers.

### *Young people need comprehensive, coordinated services with multiple points of access.*

Projects with the greatest success have designed very open systems with multiple points of access—through schools, churches, businesses, agencies, and providers. Rather than narrowing the channels to access services, they offer many ways, many options. But grantees advocate linking all channels to a mechanism to coordinate care and streamline service entrees.

### *Communities need to address employment and economic development issues to improve adolescent health.*

Those interested in improving the health of young people need to connect adolescent development with local education and economic initiatives, grantees attest. Finding ways to expand local economic horizons, create opportunities, and attract businesses are challenges common to many communities. But they may be as pivotal to fostering adolescent hopes as community development.

## *Youth development is a more prudent investment than punishment.*

As much as we all desire to live in a secure society, more cells and bigger prisons will not keep us safe. We need to give young people a stake in the future—to convince them by our collective actions that we expect them to contribute, to grow, to prosper in the years ahead. Investment in education and health care is one tangible way of communicating a more hopeful set of expectations.

## *Role models, outreach, and culturally-competent models of care enhance the effectiveness of programs targeting adolescents.*

To bridge the gap between young people and programs and services designed to help them, grantees relate their successes with various strategies. Outreach workers, mentors, and other role models, many grantees tell us, are key to connecting with adolescents and providing support and guidance.

## *Providers targeting youth must work with and through adults in the community to foster health and hope in adolescents.*

Grantees urge providers and others working with young people to seek the active involvement of parents and other adults to address adolescent health issues. Programs never treat a single person, grantees tell us. Each person is part of a family, neighborhood, or culture that has bearing on the young person's development.

## *School-based health care services are an effective outreach tool with young people.*

Although many people associate school-based clinics exclusively with sex education and birth control issues, grantees know their capabilities extend beyond these highly politicized issues. School-based health care can effectively bring services to the people they aim to serve. And what they learn about health issues and gaps in service can inform health decisionmaking and allocation of resources at the community and state levels.

# *Getting Our Bearings:* Implications for Providers, Programming, and Policy

**The experiences of Kellogg Foundation grantees—the strides they have made and the long-term challenges they anticipate—have implications for decisionmakers in many of our nation's institutions. Leaders in community-based projects call for policymakers, funders, and providers to identify ways to support community-based efforts and participate in the process of protecting youth.**

## How Policymakers Can Improve Adolescent Health

Create policy options that acknowledge the complexities of changing behaviors, habits, and expectations.

Look for ways to streamline regulations and simplify bureaucracies to allow community-based and public agencies to meet health needs and receive payment.

Seek to fund research that will expand societal understanding of the many determinants of adolescent health—including physical, social, emotional, cognitive, economic, and cultural factors—and of the service models that can address them.

Examine health professions education and health services funding to expand the availability of midlevel and outreach providers to address community health needs.

Explore policy options that foster coordination and collaboration within communities to address complex problems.

Support community efforts to address adolescent health issues now as a way of reducing costs later.

Link community development grants to health service and other delivery programs.

## How Funding Organizations Can Improve Adolescent Health

Support innovative approaches and long-term data collection and analysis to evaluate the actual costs and long-term benefits of investing in youth.

Communicate accurate information about the conditions that hamper youth development and all the causes of ill health—including those related to current policies and systems.

Support faith-based and other nontraditional programs that improve adolescent health and community safety.

Support projects that promote coordination of resources within communities.

Respect the fact that change—in communities, in systems, in people—takes time.

## How Providers Can Improve Adolescent Health

Foster the use of multidisciplinary teams to address complex adolescent health issues.

Seek to provide data on adolescent health status and youth conditions to decision-makers in business, government, education, and higher education.

Identify service barriers related to Medicaid and managed care regulations and advocate within local, state, and federal systems to improve service to vulnerable clients.

Develop protocols for adolescent health care that include linking with enabling services and local resources.

Recognize the value of culturally-competent models of care and promote training and continuing education of health professionals consistent with its approach.

Work with and through community resources—community-based organizations, midlevel providers, and outreach workers—to streamline access for young people and their families and provide needed care.

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